DOCUMENT RESUME

ED 172 097 CG 013 539

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TITLE	A Developmental History of the Georgia Life Skills for Mental Health Program.
INSTITUTION	Research for Better Schools, Inc., Philadelphia, Pa.
SPONS AGENCY	National Inst. on Drug Abuse (DHEW/PHS), Rockville, Md.
PUB DATE	Sep 78
NOTE	194p.; For related document see CG 013 538
EDRS PRICE	MF01/PC08 Plus Postage.
DESCRIPTORS	Classroom Materials; *Daily Living Skills; Elementary Secondary Education; *Humanistic Education; *Interpersonal Competence; *Material Development; *Mental Health Programs; *Program Development; Social Behavior

ABSTRACT

A developmental history of the Georgia Life Skills for Mental Health program is presented. The program's purpose is to help students aged 5-18 learn ways to handle stress, make major life decisions, and form more satisfying interpersonal relationships. In addition to a narrative description of how the program was conceived and developed, the report contains, in various appendices, the major documents generated during the developmental phase of the program. The purpose of the report is threefold: (1) to document, through the use of files and selected interviews, the development of the Life Skills Program from its inception in the Winter of 1976 to June 30, 1978; (2) to offer sets of objectives and desired outcomes which will be useful in establishing evaluative criteria and developing instrumentation; and (3) to provide a context for later interpretation of process and outcome evaluative findings. (Author/BP)

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A DEVELOPMENTAL HISTORY OF THE GEORGIA LIFE SKILLS FOR MENTAL HEALTH PROGRAM

February 1976 - June 1978

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September, 1978

CG013539

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INTRODUCTION

This report represents an intermediate product in a continuing comprehensive evaluation study of a primary prevention program for alcohol and drug abuse. The overall study is being conducted on a state-wide basis throughout Georgia by Research for Better Schools (RBS) under a grant from the National Institute on Drug Abuse.

Research for Better Schools is a private, non-profit, educational laboratory established in 1966 under Title IV of the Elementary and Secondary Education Act. RBS's primary objective is to assist education, government, business and community agencies in improving the instruction they provide to children, youth and adults, through: applying technology to develop effective educational products and systems; providing training and technical assistance in educational planning, management and instruction; and evaluating the effectiveness of educational policies and programs. RBS is governed by a Board of Directors whose members are selected to represent a variety of viewpoints in policy-making for educational institutions. Under their leadership, RBS has become a full-service educational research and development agency, offering a broad range of products and services, including: curriculum packages, evaluation assistance, management programs, training workshops, and technical assistance in a variety of areas.

The contents of the present report provide a developmental history of the Life Skills for Mental Health program, the subject of the primary prevention evaluation study. In addition to a narrative description of how the program

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was conceived and developed, the report contains, in various appendices, the major documents generated during the developmental phase of the program.

The purpose of the report is threefold:

- To document, through the use of files and selected interviews, the development of the Life Skills Program from its inception in the Winter of 1976 to June 30, 1978.
- To offer sets of objectives and desired outcomes which will be useful in establishing evaluative criteria and developing instrumentation.
- To provide a context for later interpretation of process and outcome evaluative findings.

Description of the Program

The Life Skills Program was developed and is currently being implemented statewide in Georgia under the aegis of the Prevention Unit within the Division of Mental Health/Mental Retardation of the Georgia Department of Human Resources (DHR). DHR is an umbrella human service agency with responsibilities in the areas of welfare, physical health, mental health, mental retardation and juvenile problems.

The program is implemented through the public schools and has enlisted the support of the State Department of Education, local school districts and community mental health centers (CMHCs). The program delivery system is such that it involves a training of trainers process whereby a State Training Team representing DHR conducts an annual set of workshops for the purpose of preparing and training a number of CMHC teacher training teams which then, in turn, conduct their own training of teachers workshops with school districts to help interested teachers understand the basic concepts of the program and implement the Life Skills activities in their classes.

The Life Skills program presents the opportunity for learning basic intrapersonal and interpersonal skills which help in handling stress, responding to major life decisions, and forming more satisfying interpersonal relations. These skills are basically the same skills that many mental health helpers use and teach when they work with people in temporary crises. The distinctive intent of this program is to teach these skills as an educational experience (preventative) rather than as a therapeutic experience (curative). As a result, young people exposed to the program should be better prepared to take responsibility for their lives without recourse to drugs and alcohol. They should be able to resolve personal problems before they become crises. More specifically, program developers hope that participation in Life Skills for Mental Health will help young people:

- Identify their own personal talents and qualities and appreciate the contributions they can make.
- Evaluate the alternative choices they have in important decisions and explore the consequences of each alternative.
- Clarify important value issues, especially in the face of conflicting messages. When young people have the opportunity to decide what is important to them and have learned to stand up for their convictions, they are less susceptible to peer pressure.
- Express themselves verbally and to feel less anxious in doing so, so that sharing feelings, standing up for oneself and responding openly to others will be options available to them in positive interactions and in conflict situations.

Teachers participating in the program receive 12-18 hours of training in their area by teams comprised ideally of both local community mental health personnel and educators. Teachers are also providing a Life Skills Activity Guide appropriate to the age level they teach. The guide describes life skills activities and provides strategies for integrating them into daily classwork.

Context of Evaluation

Research for Better Schools, through its participation in the present study, and the National Institute on Drug Abuse, through its sponsorship of the study, have indicated their belief that the Life Skills program represents an approach to primary prevention which has significant potential and which merits close evaluative scrutiny. By utilizing community mental health agencies as the link between program sponsors and the public schools, the Prevention Unit has developed a new program dissemination strategy which deserves rigorous testing and careful refinement. As such, the RBS evaluation study examines in the Life Skills program a prototype which could hold great import for the prevention field.

In July/August of 1978, Research for Better Schools accelerated its work on the Life Skills program by sending staff members to Georgia. Their objectives included the following: gathering information for the present documentation, and interviewing pilot and '78 cohort team leaders. As a part of the former task, members of a Joint Committee (Georgia Departments of Education and Human Resources) established to assist in development and dissemination of the program were contacted during the beginning of August and asked if they would consent to being interviewed concerning their role in the development of the program and their perception of the problems and issues it faces and the successes it has achieved. Seven of the members agreed and subsequently were interviewed, as described above, on their role in the development of the Life Skills program and their perceptions of the program. Three members felt it was inappropriate for them to comment because they felt they had only peripheral involvement and, due to other commitments, were not active after the first committee meeting when the initial strategy statement was approved. The responses and comments of most of the other committee members are integrated within the corpus of this work. Such information provides both an elaboration upon the documents collected as well as a perspective or context within which the documents can be placed.

The balance of the report which follows contains what might be considered the twelve major chronological milestones in the development of the Life Skills for Mental Health program - arranged into two major sections, Program Development and Pilot Program Implementation, followed by a concluding section and Appendices. These twelve milestones along with the dates of their occurrence are presented below.

May-July 1976	Seeking Approval for the Life Skills Concept
July 1976	Establishment of the Joint Committee
July-August 1976	Early Interactions with Local Community Mental Health Centers
September 1976	Development of a Strategy Statement
Oct. 1976-Sept. 1977	Development of the Life Skills Activity Guides
February 1977	Selection of Pilot Areas for Training
January-May 1977	Development of Teacher Training Package
June 1977	Training of the Pilot Community Mental Health Center Teams
August-October 1977	Development and Use of Slide Presentation
September 1977	Training for Certification Renewal Credit
Nov. 1977-June 1978	Organization and Activities of the State Training Team
March 1978	Solicitation of Teams for Statewide Implementation

Each milestone is discussed separately and in the order presented above. A concluding section then follows which presents comments of Joint Committee members on the future of the Life Skills Program together with a discussion of the issues which this program must address if it is to continue to achieve success in its diffusion efforts.

PROGRAM DEVELOPMENT

The history of the Life Skills concept dates back to the creation of an Office of Prevention by the 1976 Session of the General Assembly. Under Section 88-603 of the Mental Health Services Act (Act Number 1136) the law states that "The Department (of Human Resources) shall assign specific responsibility to one or more identified units of the Department for developing a coordinated program of research, education and service dealing with all aspects of prevention of mental disability...."

In February, 1976, the Division of Mental Health/Mental Retardation established the Office of Prevention as an Office of the Division, with responsibilities for reducing the occurrence of mental retardation, alcohol and drug problems and other mental health related problems.

Prior to February 1976, prevention programming in the Division of Mental Health and Mental Retardation had been a fragmented effort. Most prevention activities resided within the Alcohol and Drug Section and the Office of Child and Adolescent Services. The newly created Office of Prevention felt a need existed for a comprehensive prevention program which would address the major mental health related problem areas. The Life Skills for Mental Health program has become the tangible outcome of this perceived need.

Seeking Approval for the Life Skills Concept

A strategy outline and timeline for development and implementation of the Life Skills Program was promulgated in May of 1976. Towards the end of May, the Single State Agency for Georgia approved the program. In June, Office of Prevention staff received approval from the Director of the Division on Mental Health and Mental Retardation to proceed with the program.

During June and July the outline was circulated to the following people within the Division of Mental Health/Mental Retardation for review and comment: the Director of the Alcohol and Drug Section, Members of the Prevention Committee of the Division, the Prevention Subcommittee of the Governor's Alcohol and Drug Advisory Council, community mental health center directors and Superintendents of Regional Hospitals.

Concurrently the Division Director sought and obtained approval and support for the program from the Commissioner of Department of Human Resources. The Commissioner agreed to meet with the State Superintendent of Schools in an effort to obtain the cooperation and involvement of the State Department of Education. In preparation for this meeting, a proposal was developed which is included in Appendix A of this report. The proposed plan for a joint working relationship involved the following elements:

- the appointment of several staff from the State Department of Education to serve as liaisons between the Office of Prevention and the State Department of Education. Office of Prevention requested representation from the following areas: Health and Physical Education, Guidance and Counseling and Staff Development.
- the development of a mental health education guide which would provide clearly defined group and individual exercises and expected outcomes which teachers could use in their classrooms.
- the development of a training program to prepare teachers to use the guide in their classrooms.
- the establishment of cooperative relationships with community mental health centers to provide in-service training and continuing technical assistance to schools that request the program.

- the establishment of a cooperative relationship between local school systems and community mental health centers whereby schools would contract for staff development in mental health education from community mental health centers and teachers would receive in-service credit.

The State Superintendent of Schools agreed to the plan in late July, 1976. This was rapdily followed by completion of the proposal's first objective.

Establishment of the Joint Committee

The first objective of the proposal was to appoint Department of Education staff to serve as liaisons between the Office of Prevention and the State Department of Education. The State Superintendent of Schools selected two individuals each from curriculum development, health education guidance and counseling, and one from staff development to serve in this capacity. These seven individuals along with the director and assistant director of the Office of Prevention and a community mental health center representative formed what will forthwith be called the Joint Committee. (A list of committee members and their positions can be found in Appendix A of this report.) The committee was designed so that responsibility for content and mechanics of the program could be shared and monitored by all involved parties. Other functions of the committee included a content review of the leader guides, development of a training package for teachers, and facilitation of program dissemination through contacts made by committee members.

Early Interactions with Local Community Mental Health Centers

In Georgia, local community mental health centers have considerable personal autonomy. The Office of Prevention began cultivating relationships with the local CMHCs by asking each center director to appoint a prevention coordinator. As a planning tool, the Office of Prevention developed and distributed a survey to these newly appointed prevention coordinators in July of 1976. The survey assessed the following five areas:

(1) The types of services that schools most often request from CMHCs and the services that CMHCs are able to provide consistently to the school systems.

(2) The educational grade levels that CMHCs most often work with and the proportion of public and private schools with which the CMHCs currently are active.

(3) The specific areas of interest of the CMHCs in aiding in the development and implementation of a comprehensive Mental Health Education program for the schools.

(4) The types of training that CMHC staff have had which would be useful in various phases of developing and implementing this Mental Health Education program, and the additional training the staff at the CMHCs feel they would require specifically to provide in-service workshops for teachers interested in the program.

(5) The problems and the sources of support that the CMHC staff expect in implementing a comprehensive Mental Health Education program in the local schools.

Responses were received from 24 of 36 CMHCs. Data from the completed surveys was compiled by Office of Prevention staff and released in a report in August of 1976.

The report indicated a substantial CMHC involvement in the schools. Services provided by CMHCs to the schools (whether requested or initiated by CMHC staff) were grouped into six major categories:

(1) Activities with student groups.

(2) Evaluation and consultation activities.

(3) Teacher in-service training or teacher workshops.

(4) Direct Client Care.

(5) Activities with communities and parent groups.

(6) Provision of mental health resources (films, books, pamphlets, etc.)

The report noted that in every category the amount of service provided by the CMHC to the schools exceeded the amount of service requested of the CMHC by the schools. The difference was most marked in the area of teacher training, where four times as much activity is carried on as is requested. It was also significant in the areas of treatment and community/parent contact, where the difference was twofold. The figures indicated to Office of Prevention staff (1) the ability of the CMHCs to fill thus far the requests of the schools for service and (2) a considerable independence and initiative on the part of the CMHCs in carrying their ideas and programs to the schools. Office of Prevention staff were also gratified to see that the single most important priority of the CMHCs' school programs is teacher in-service training or teacher workshops.

The survey also indicated a willingness on the part of CMHC staff to participate in the development and implementation of the Life Skills for Mental Health program. The report separated responses of those CMHC workers involved in school-related activities at the primary level from those working at the secondary level.

On the primary level, 81% of those surveyed expressed willingness to be involved in both development of the leader's guides and the teacher in-service workshops. Sixty-two percent were interested in taking the program to the schools once the program was developed. On the secondary level, response was somewhat less favorable towards developmental activities. Nonetheless they did express an equivalent level of interest as primary school workers in the willingness to implement teacher training activities.

When questioned about staff training needs around the Life Skills program, respondents' answers were quite varied. Less than one-half of respondents felt they needed additional training in skill areas embodied within the Life Skills program. The largest single request was for better resource materials. A number of respondents felt the need for more information on the objectives and content of the Life Skills program before they could address the question.

The CMHC respondents were also asked to address themselves to any potential sources of problems and/or support for the Life Skills program in the schools. They saw the problems they would encounter centered around teachers and administrators. Teacher enthusiasm was anticipated by only 33% of the workers whereas 38% of the workers expected no interest on the part of the teachers; 76% anticipated that lack of release time for teachers for training purposes would be a significant difficulty and 43% expected that teachers would feel threatened by the program. Forty-three percent expected that the school administration would not be interested or would feel that mental health education was inappropriate for the schools (this was especially true in rural catchment areas), although 57% expected endorsement of the program by school administrators. Parents and students were viewed as sources of support for the program. Other community agencies that could assist in teacher in-service training or give other sources of support were expected by a majority of the workers to aid in the program's implementation. Finally, 24% of the workers anticipated a problem with CMHC staff time and/or funding.

Copies of the survey forms utilized and the complete text of survey findings can be found in Appendix B.

Development of a Strategy Statement

The next step Office of Prevention staff took was the development of a strategy statement for the Life Skills for Mental Health program. In this effort, Office of Prevention staff received support from other central staff, several community mental health center people and representatives of the State Department of Education. The document offered a rationale for the program, defined terms and presented a step-by-step plan with a timetable for the development and implementation of the Life Skills program.

The statement is included in this report as Appendix C. The strategy statement was approved by the Joint Committee during their first meeting in September of 1976.

The Office of Prevention saw the Strategy Statement as a working document. They distributed it throughout the state and to some federal agencies in the Fall of 1976. Recipients were organizations and agencies with any potential involvement or stake in the program. Some of the groups which received the statement are listed below:

Area Mental Health Program (Directors, Prevention Coordinators and Child and Adolescent Services Staff)
Mental Health Consortium Directors
District Health Officers
Prevention Subcommittee of the Drug Abuse Advisory Council
Alcoholism Advisory Council
Governor's Advisory Council on Mental Health and Mental Retardation
Representatives of the State Board of Education
Georgia Association of Educators
Education Improvement Council
Georgia Congress of Parents and Teachers

Medical Association of Georgia - Education Committee
Southern Regional Education Board - Commission on Mental Health
and Human Services
Georgia Psychiatric Association
Georgia Mental Health Association
Altanta Mental Health Association
National Institute on Mental Health Education Branch
National Institute on Drug Abuse - Office of Prevention

Groups were asked to provide feedback and to present any concerns, suggestions, or reservations they might have. While most comments were favorable, a number of concerns were raised which bear watching as the Life Skills program matures.

Conceptually, there was some concern that the Life Skills program would fail to meet its objectives because (1) it lacks a clear theory of intervention which is supported by research, and (2) it is attacking the wrong problem. It was noted that the project's assumption of a causal relationship between feelings and psychodynamics of children and their later life adjustment was not supported in the literature. It was suggested that the Office of Prevention engage in prevention activities where clear-cut etiologies are present, such as in the area of mental retardation or schizophrenia.

Another concern, frequently expressed was the seeming lack of involvement of teachers, administrators and CMHC staff on the local level in the development of the program. One reviewer made the point that school systems are quite independent and will not become involved merely because the State Department of Education recommends it. In order to insure school system involvement, this reviewer recommended that individuals involved in the eventual implementation of the program be involved as soon and as frequently as possible.

An additional concern was the length of training to be provided (12 hours as indicated in the Strategy Statement). One reviewer felt the time allocated to be "...utterly unrealistic to establish reasonable levels of the skills required to implement the activities in the guide..." To support his claim, he cited two studies which document student change only after intensive systematic training and supervision of teachers totaling at least 40 hours.

One reviewer noted that the Strategy Statement suggests that teacher training be made a reimburseable service paid for by local school staff development funds. She suggested this might lead to conflict with the CESA (Cooperative Educational Services Agency) in her area which is already contracting with school systems for staff development.

Another concern related to the appropriateness of charging teachers for training in the first place, since the program was developed in cooperation with the State Department of Education. This could be compounded by the fact that educators may be included on the training teams.

Appendix C also contains two of the more detailed responses to the Strategy Statement along with Office of Prevention replies. Names and professional affiliations have been deleted from the correspondence.

Development of the Life Skills Activity Guides

Work began on the development of guides for teachers utilizing the Life Skills program in October of 1976 and continued for almost a year until August of 1977. Office of Prevention staff utilized the following guidelines for development of the Guides (as set forth in the Strategy Statement):

1. Four guides will be developed for four age ranges: 5-8 years; 9-11 years; 12-14 years; 15-18 years.

2. The guides will offer step-by-step instructions for structuring experiences to help students learn interpersonal and intrapersonal life skills and to explore critical issues they are facing.

3. Guides will be designed to be useful to teachers but also to youth group leaders and others who regularly interact with young people.

4. Activities in the guides will be designed to be integrated into regular class activities so that a separate course requiring a special teacher will not be needed. As such, the guides will be useful as resource materials for all teachers regardless of the subject area taught.

The first step in development of the guides was to review the body of material already extant in the field of mental health education. Three major content areas emerged from this review and objectives were developed for each content area. The same content areas and objectives served for the development of each of the guides. Major content areas chosen were: (1) acceptance of self and others, (2) feelings and (3) being with others. Goals and objectives which relate to each of these areas can be found in Appendix G of this report.

For the most part, activities selected for inclusion in the guides were adapted from the various mental health education materials collected by the Office of Prevention. Examples of some of the materials utilized include: Inside/Out Teachers Manual developed by the Agency for Instructional Television; Toward Affective Development by the American Guidance Service

Inc.; A World to Grow In by the Educational Research Council of America and Life Skills for Health - Focus on Mental Health developed by the Division of Health, Safety and Physical Education of the North Carolina Department of Public Instruction.

Guides were developed individually. After the preparation of a draft the guide was sent along with a review sheet (see Appendix D) to appropriate state level individuals and organizations, all community mental health centers, a number of teachers, administrators and counselors active in various school systems in Georgia and staff development personnel at the State Department of Education. Responses were tallied by various members of the joint committee. The committee then met to discuss revisions.

All of this information was then utilized by Office of Prevention staff to prepare a final version of each Life Skills for Mental Health Activity Guide. Final printing of all four of the guides was completed by December of 1977.

Selection of Pilot Areas for Training

In early February 1977, a memo was sent to all CMHC directors and prevention coordinators. The memo invited them to participate in the pilot phase of the Life Skills Program, outlined what their commitment would be if they chose to participate and delineated the immediate steps they should take if interested. CMHC s were asked to respond to the Prevention Unit in writing by March 1, if they were interested. Twelve of Georgia's 34 CMHC s asked to participate.

The Joint Committee met in March to select pilot areas from among the centers that asked to participate. Criteria for selection of pilot areas was based on: (1) previous prevention related activities, (2) staff available, (3) expressed interest in the program, (4) demonstrated relationships with school systems, and (5) perceived receptiveness of school systems to the Life Skills Program.

Eight centers were chosen for participation. Letters were sent to them in late March confirming their involvement and presenting guidelines for the selection of team members. This letter, the initial memo and a listing of the eight areas chosen can be found in Appendix E of this report.

Development of Teacher Training Package

Work on this component of the Life Skills program began in January of 1977 with a meeting of Office of Prevention staff and the Joint Committee member representing community mental health centers. At this meeting an outline was developed for the training package which included: a delineation of skills needed to effectively implement the Life Skills program and issues that merited inclusion in the training. The CMHC representative agreed to coordinate development of the training package.

To assist in development of the teacher training package, Office of Prevention staff developed and received funding for a proposal providing consultation support from the U. S. Office of Education Southeast Regional Training Center. As a result, two consultants were retained to develop various training components and to assist in the early training efforts. These individuals and the CMHC representative met in March of 1977 to define areas of responsibility and develop a mechanism for review of drafts. A third consultant was brought on in late March to assist in the process.

In these discussions, four strategies emerged as being integral to achievement of Life Skills program objectives in the classroom. The four strategies and their respective purposes are outlined below.

1. Listening for Feeling - To facilitate students' awareness, expression, and acceptance of their own feelings; to facilitate teachers' understanding and acceptance of their students' feelings.

2. Behavior Feedback - To help students become aware of the effect their behavior has on others; to enable teachers to express that effect in a way that will not damage the students' self-esteem, but will help them understand that effect and change their behavior (where necessary).

3. Values Clarification - To help students become aware of, express, explore and affirm their personal values; to facilitate an understanding of the values of others.

4. Role Playing - a. To facilitate the demonstration of life situations and interpersonal relationships, and to enable them to become real by providing students the opportunity to experience the thoughts and feelings underlying their behavior.

   b. To facilitate learning, by both teachers and students, to identify problems, explore alternative solutions, to project consequences of actions, to understand causes of behavior, and to empathize.

A theoretical construct, tying these strategies together and linking them with the utilization of Life Skills material in the classroom, was also adopted at this time. The construct is entitled "affective integration." Its practical application points out ways that teachers can emerge Life Skills activities with the cognitive materials they present in class.

The four strategies coupled with the affective integration construct became the core of the training to be provided teachers. Between March and May of 1977, each area was expanded, illustrated with examples from the Life Skills Activities Guides and formated to provide a 2 - day workshop for teachers.

Developers of the training materials also drafted a set of objectives they considered attainable if the work shop was implemented properly. These objectives are presented below.

1. To create an awareness of the importance of affective education.

2. To increase understanding of the relationship between affective and cognitive learning.

3. To increase teachers' confidence in their ability to conduct Life Skills activities.

4. To motivate teachers to implement Life Skills activities in their classrooms.
5. To facilitate personal knowledge and skill in Life Skills strategies.
6. To demonstrate selected Life Skills activities.
7. To provide a resource for additional training, consultation and materials.

A draft of the workshop format was approved by the Joint Committee in May of 1977.

To determine the efficacy of the workshop format, Office of Prevention staff arranged with Dekalb County Schools to conduct a run through of the materials with 17 teachers and administrators. Sessions were conducted on May 23 and 24, 1977 by the CMHC representative and two of the consultants. Feedback from the participants was solicited and then reflected in changes made to the workshop materials.

PILOT PROGRAM IMPLEMENTATION

The foregoing sections of this report have described and documented what might be considered to be essentially the developmental phase or stages of the Life Skills for Mental Health Program. With the completed development of the Activity Guides and Training Package, the Life Skills for Mental Health Program. With the completed development of the Activity Guides and Training Package, the Life Skills Program began to shift its emphasis toward a pilot program implementation or program "try-out." This pilot implementation would serve as a field test for the program and a precursor to the dissemination and diffusion activities which would come later. The sections which follow describe the activities and events which became a part of the Life Skills pilot program implementation.

Training of the Pilot CMHC Teams

The working group responsible for the development of the teacher training workshop also designed and conducted the first training session for trainers or CMHC teams. The format for that first training of trainers session called for essentially a "walk through" of what might be considered a well-implemented teacher training workshop. The intent was learning through modeling. Time was allowed in the workshop format for discussion of questions and problems relating to training strategies. A block of time at the end of the workshop was also set aside to provide "tips for trainers." A total of 15 1/4 session hours was planned. A schedule for the workshop can be found in Appendix F of this report.

The workshop was held on June 7, 8, and 9 at the Center for Continuing Education, University of Georgia. Thirty-four CMHC team members were trained. Of these thirty-four, eighteen were mental health workers, eight were educators, seven considered themselves "other" (this group included 4 individuals who saw themselves as educators and mental health workers) and one individual who declined classification.

At the close of the workshop, participants were asked to evaluate the experience along a number of dimensions. One of these dimensions asked participants to rate the extent to which the workshop met its stated objectives. Responses to this dimension are presented in Table 1. One participant declined to respond.

The table indicates that most participants felt the objectives were successfully attained. Objectives with lowest ratings (although still relatively high) included: facilitation of trainers' personal knowledge and skill in Life Skills strategies; provision of resources for additional training, consultation and materials; and development and/or increase in trainer's confidence in ability to conduct life skills teacher training workshops.

A summary of responses to the entire evaluation questionnaire can be found also in Appendix F of this report.

In October of 1977, a follow-up workshop was held for the pilot teams. The workshop had two objectives: (1) to help solve problems encountered in implementation of teacher training workshops; and (2) to spend additional

Table 1

Accomplishment of Workshop Objectives

	Very Successful 5	4	Somewhat Successful 3	2	Un-Successful 1	Mean Rating
Objectives:						
1. To increase understanding of the relationship between affective and cognitive learning.	16	13	4	-	-	4.36
2. To reinforce the rationale for promoting positive affective and cognitive growth as a prevention strategy in mental health.	15	11	6	1	-	4.21
3. To create an awareness of the importance of training in Life Skills strategies and activities.	14	13	7	-	-	4.21
4. To introduce the Life Skills Program as a vehicle for positive development/prevention, and to demonstrate selected activities.	13	16	3	1	-	4.24
5. To facilitate trainers' personal knowledge and skill in Life Skills strategies.	8	20	4	1	-	4.06
6. To demonstrate various training styles.	17	9	6	-	1	4.24
7. To develop and/or increase trainers' confidence in their ability to conduct Life Skills teacher inservice training.	10	11	9	3	-	3.85
8. To provide resources for additional training, consultation and materials.	8	16	8	1	-	3.94

training time in the four strategy areas (listening for feeling, behavior feedback, values clarification and role playing). Eighteen team members (12 mental health workers), 2 educators and 4 "others" attended the 2 day workshop. The working group that ran the June workshop also ran this follow-up. To prepare for specific problems, a brief questionnaire was distributed to all team members six weeks prior to the scheduled workshop. Workshop organizers used this feedback to help structure the workshop schedule found also in Appendix F.

Response to this workshop was generally favorable. Almost all team members were pleased they participated. Over ninety percent felt their expectations were at least "somewhat realized." A summary of responses to an evaluation questionnaire distributed at the end of the workshop can be found also in Appendix F of this report.

Development and Use of Slide Presentation

Between August and October of 1977, a slide/sound presentation was developed to introduce the Life Skills for Mental Health program. It was designed as a means for generating awareness of the goals and objectives of the program, the types of activities involved, and the kind of outcomes to be anticipated. The awareness presentation runs 16 minutes in length. All CMHC teams trained have received copies of the slide show. It has been used on the local level to introduce interested groups to the Life Skills concept and to orient participants in teacher training sessions. On the state level, the slide show has been presented to the Alcohol and Drug Section (SSA), representatives of the Citizens Advisory Council on Drug Abuse, the Georgia School of Alcohol and Drug Studies, the Steering Committee of the Governor's Advisory Council on Mental Health and Mental Retardation, the Prevention Task Force of the Division of Mental Health and Mental Retardation, a representative of the Prevention Branch of the National Institute on Drug Abuse and to other interested agencies and individuals within Georgia and from neighboring states.

The development of the slide/sound awareness presentation not only served as a useful part of the Life Skills pilot implementation phase, but also represented an initial step toward effecting what would later become a major dissemination/diffusion effort.

Training for Certification Renewal Credit

In September of 1977, the State Department of Education approved the Department of Human Resources' Staff Development Plan for Certification Renewal Credit. The plan represents one of the most significant accomplishments of the Joint Committee. It means that teachers can earn credit toward certification renewal by participating in a somewhat modified Life Skills training program designed to consist of twenty contact hours. The twenty hour program is broken down as follows:

14 hours	Inservice Workshop (the same workshop presented to all teachers, with more time to practice the strategies)
1 hour	Practice Plan (to be completed by the teacher after the workshop and approved by the training team)
4 hours	Follow-Up to teachers after they have had a chance to try the strategies with Life Skills activities in their classrooms

1 hour   Implementation Plan (completed by the teacher after follow-up and approved by the training team)

After the twenty hours are completed, teachers are observed in their classrooms to verify that they have met the stated competencies and that they are using the Life Skills resources appropriately. This teacher assessment is usually completed by members of the training team, who frequently receive assistance from the school system.

Training teams have the option to offer Life Skills for staff development credit. The process involves routine completion of a number of forms plus the additional time to follow-up and assess the teachers. However by offering the training for credit, teachers are provided with an additional incentive to sign up for the training. Also, teachers taking the training for credit are more willing to spend time outside of class in training sessions, thereby providing a resulting flexibility of scheduling for the trainers which would not otherwise be available.

A copy of the Staff Development Plan is presented in Appendix G of this report.

Organization and Activities of the State Training Team

During November and December of 1977, Office of Prevention Staff recruited six individuals from the eight pilot teams to serve as a state-level training team. The team's function was envisaged as three-fold:

1. To provide technical assistance in training and advanced training as needed to current local teams in the pilot areas.
2. To provide basic training to new members of current teams as vacancies occur and are filled.

3. To provide training in special situations to schools or other groups in areas where training is not available from the community mental health center.

By recruiting six team members, Office of Prevention staff sought to minimize the time any one individual would spend in state training activities, as each team member also has full-time job responsibilities.

A special training session was held for team members on February 21 and 22, 1978. This session allowed team members to arrange working relationships with each other and also provided intensive training from the consultants who conducted the original pilot training of trainers workshop.

Since its initial organization, the state team has provided training for the '78 cohort of CMHC teacher training teams and has also trained a group of teachers involved in piloting student competency-based education programs in Georgia. Additionally, the state team has provided input to the revision and reorganization of the training of trainers workshop format.

Solicitation of Teams for State-wide Implementation

State-wide implementation of the life skills program was initiated with a memorandum dated March 14, 1978 from the Director of the Division of Mental Health and Mental Retardation to CMHC program directors and prevention coordinators across the state. The memo invited centers to participate and informed them of their responsibilities if they chose to do so. A copy of this memo can be found in Appendix H of this report.

The memo asked centers to notify the Prevention Unit by May 1, 1978 if they were interested in participation. A total of 11 centers responded affirmatively.

This solicitation represented the end of the development and pilot implementation stages of the Life Skills Program and marked the beginnings of a new dissemination/diffusion phase.

With this change in program mission comes new challenges to be faced. As the program gains wider visibility and utilization, a greater scrutiny of the merits of the program itself must be made within the context of an overall formative and summative evaluation plan.

A comprehensive evaluation of the Life Skills program is currently underway.

CONCLUDING REMARKS

This section presents a discussion of issues arising out of the development and trial implementation of the Life Skills Program as well as the perceived challenges which lie ahead as the program undertakes its statewide dissemination/diffusion effort. These issues were identified and addressed in interviews with Joint Committee members conducted in August of 1978. The results of these interviews form the basis for the concluding remarks which follow.

In general, committee members felt that the future holds considerable promise for the Life Skills program. Cited as an example was the fact that over half of all CMHCs in Georgia have already received Life Skills training. However the committee members also saw some unresolved issues which posed potential problems for the Life Skills program. These issues are discussed below and are then followed by some additional supportive observations on the present and future course of the Life Skills Program.

One issue identified as particularly problematic for the program, according to committee members, is the question of whether or not local school systems should be charged for Life Skills Training Workshops. Committee members were found to be somewhat polarized on this issue. Members from DHR expressed the concern that unless the training teams initiated some charge for their training services, the essential tendency would be toward a redirection of team members' energies to activities that are cost-reimbursable. In some catchment areas this has become a critical issue due to greatly increased demand for Life Skills Training. Unless team members in these CMHCs are able to charge for their services, there exists the real possibility that the Life Skills program in these centers may be curtailed.

On the other hand, those committee members from the Department of Education, expressing an opinion, believed that because the State Department of Education participated in the initial development of the program, local school systems should receive the training at no cost.

Considering a related issue, committee members expressed concern that there may spring up competition between local CMHCs and the Cooperative Educational Service Agencies (CESAs) in their areas. The CESAs are in the full-time business of providing training on a contract basis to local school systems. Offering Life Skills training, particularly at a cost, to local school systems could be perceived as putting the CMHC in direct competition with the CESA for local school monies. This problem could be ameliorated, according to one committee member, through active solicitation of CESA support early in the planning of the workshops. This, followed by regular updates, could help convince CESAs that the Life Skills training poses no real threat to their roles, responsibilities and overall mission.

The same committee member evinced some frustration concerning the fact that CESAs were not really being used to their full potential as resources in the effort toward statewide dissemination/diffusion of the Life Skills Program. He noted that the CESAs have established intimate relationships with the local school systems and these could be used to good advantage. They could, for example, serve to facilitate acceptance of the Life Skills program even in unreceptive school systems.

An issue of particular concern to those committee members from DHR is the problem of staff turnover on the training teams. A number of team leaders and team members trained in the pilot group and the '78 cohort, have either left their original positions or have been reassigned to assume other responsibilities within their respective CMHC. Since the Prevention Unit can schedule only one major training session for team members per year, this seriously limits training activities on the state level that might otherwise serve to ameliorate this problem. Committee members and Prevention Unit staff acknowledged that some policy to keep track of turnover and to control the training of potential team members needs to be formulated in the near future.

While the aforementioned issues are problematic, committee members felt that, overall, the future did indeed appear bright for the Life Skills program. Over one half of all CMHCs have thus far received training. School systems are generally receptive to the program and in some areas demand has exceeded expectations. Moreover, informal feedback suggests that teachers are satisfied with the training experiences they receive.

All committee members expressed optimism concerning the joint working relationship between DHR and the Department of Education and the extension of this cooperative relationship to the local level. They believe that: (1) school counselors will become more comfortable referring students to CMHCs; (2) schools will call on CMHCs for assistance in areas related to the Life Skills program; and (3) CMHC staff will develop a more complete understanding of the school environment. Finally, a number of committee members were optimistic that the cooperative initiative embodied in the Life Skills program would carry over to other efforts. One member cited as an example a joint educational effort now being contemplated by the Division of Physical Health within DHR and the State Department of Education.

The completion of the development and pilot implementation phases of the Life Skills Program has signaled its readiness for the new challenges of dissemination/diffusion and for a comprehensive assessment of the merits of the program through evaluation of its effectiveness as a vehicle for primary prevention of alcohol and drug abuse. While showing considerable promise, the true potential of the Life Skills for Mental Health Program remains to be determined. It is hoped that the evaluation study currently being conducted by Research for Better Schools will yield information critical to this determination.

APPENDICES

APPENDIX A

PROPOSAL TO INVOLVE THE STATE DEPARTMENT OF EDUCATION WITH THE LIFE SKILLS PROGRAM

JOINT COMMITTEE MEMBERS

PROPOSAL TO INVOLVE THE STATE DEPARTMENT OF EDUCATION WITH THE LIFE SKILLS PROGRAM

Proposal for Strengthening the Relationship Between the Division of Mental Health and the Department of Education with the Intent of Reducing Mental Health Problems

The Office of Prevention of the Division of Mental Health/Mental Retardation proposes to develop a "Mental Health Education" program as one important part of a total prevention effort. The general objectives of the program are 1) to prepare mental health workers and other human service workers to respond to requests from schools, agencies, and civic groups to present programs on mental health related topics, and 2) to work with local school systems upon request to prepare teachers to incorporate Mental Health Education in the school experience.

Definition:

Mental Health Education is defined here as a learning process for basic interpersonal skills which help a person handle stress, respond to major life decisions, and form more satisfying interpersonal relationships. These skills are basically the same skills that many counselors use and teach when they work with people in temporary crises. The important intent of this proposal is that these skills could be taught more widely with people currently not in crisis as an educational experience rather than as a therapeutic experience. Teaching mental health skills will enable people to take responsibility for their lives and to handle situations before crises arise.

Rationale:

The need for a highly developed Mental Health Education program is clear. Students, teachers, and mental health workers all are handicapped by Georgia's lack of a comprehensive, coherent approach to mental health education. Yet, the stated purpose of all public education is to foster social and emotional development as well as intellectual and physical development.

Mental health professionals in public and private settings are seeing increasing numbers of people who report feelings of confusion about personal identity and goals; feelings of inadequacy and inferiority; and the inability to resolve continuing problems in significant interpersonal relationships. In some cases, the people experiencing these feelings deal with them through heavy alcohol or drug use, through attempted suicide, or through traumatic separation from their relationship, such as divorce or running away from home. When a person asks for help by entering the "treatment" system, he generally feels powerless to deal with his personal crises. Mental Health Education would offer a process for minimizing the person's need to seek help by enabling him to defuse potential crises and by strengthening his own ability to resolve crises that do occur.

School systems are pressured to introduce a new course (e.g., drug education) each time a new social problem arises. There are several problems with this approach. For one, the school curriculum can soon be so expanded with "social problem" courses, that there is little time for other learning. Secondly, these courses are usually treated as other academic subjects where students memorize facts and answer test questions. It is unlikely that this approach changes behavior. Thirdly, most teachers have been trained to instruct by giving facts and therefore they feel uncomfortable handling potentially explosive issues. Often, teachers are not prepared to handle personal behavior issues where the "facts" may not be clear, and the issues are more concerned with personal values and needs.

Similarly, many mental health professionals are asked to be part of education programs to deal with personal behavior issues. Community Mental Health Center staff are often invited to schools, PTA meetings, or civic group meetings to lecture about drugs, sex, family conflicts, communications, etc. These workers cannot be experts on each subject. And, once again, enumeration of facts is not helpful. What is needed is an approach that facilitates personal understanding.

A New Direction:

The Mental Health Education program would offer a resource to teachers and other professionals who find themselves responsible for educational programs which clearly concern social and emotional growth. It would replace a fragmented approach to scattered issues with a consistent framework for responding to a range of concerns related to interpersonal relationships, personal values, major life decisions, and self acceptance. It would prepare the teacher or mental health professional to enable their students to learn important life skills--not just facts.

A number of states have already successfully introduced a Mental Health Education program. In North Carolina's school-based program, teachers report improved communication in the classroom, improved attitudes toward school and fewer discipline problems. Students express their feelings more accurately and more productively and are able to clarify personal values.

While the Georgia program will not be limited to the school system, it is the Division's hope and intent that the program will be widely requested by local schools. For this reason, it is important to secure the support and help of the State Department of Education.

The First Step:

The Division of Mental Health/Mental Retardation requests that Mr. Jim Parham contact Dr. Jack Nix to share with him the Division's proposal and to seek his support. We request that Dr. Nix appoint one or two people to consult with us as the program is developed and to serve as liaison between the Office of Prevention of the Division of Mental Health/Mental Retardation and the State Department of Education. We suggest to Dr. Nix that representatives from Health and Physical Education, Guidance and Counseling, and Staff Development be considered for this role.

The proposed plan for working with the school system would include the following specific objectives:

1. To develop a mental health education guide which would provide clearly defined group and individual exercises and expected outcomes which teachers could use in their classrooms. (The guides would be developed for different age ranges and would cover all school-age children.)

2. To develop a training program to prepare teachers to use the guide in their classrooms

*3. To establish a cooperative relationship with community mental health centers to provide in-service training and continuing technical assistance to schools that request the program

*4. To establish a cooperative relationship between local school systems and community mental health centers whereby schools would contract for staff development in mental health education from community mental health centers and teachers would receive in-service credit

*It is proposed that this be attempted initially on a pilot basis.

JOINT COMMITTEE MEMBERS

LIFE SKILLS FOR MENTAL HEALTH
JOINT COMMITTEE

Division of Mental Health/Mental Retardation

Maury Weil, Director
Office of Prevention

Xenia Wiggins, Assistant Director for Primary Prevention
Office of Prevention

Bob Dixon, Director
Child and Adolescent Mental Health Outreach
Griffin Community Mental Health Center

State Department of Education

Claude Ivie, Director
Curriculum Development and Pupil Personnel

Victor Bullock, Director
Curriculum Development

Jack Short, Coordinator
Health, Safety and Physical Education

Rendel Stalvey
Health Education

Jerrell Lopp
Staff Development and Teacher Education

Paul Vail
Guidance and Counseling

Jerry Roseberry
Guidance and Counseling

APPENDIX B

COMMUNITY MENTAL HEALTH CENTER SURVEY FORMS

COMMUNITY MENTAL HEALTH CENTER SURVEY REPORT

COMMUNITY MENTAL HEALTH CENTER SURVEY FORMS

SURVEY OF PRIMARY PREVENTION EFFORTS WITHIN SCHOOLS

NAME

TITLE

CENTER NAME

ADDRESS

AREA CODE

TELEPHONE #

GEOGRAPHICAL AREA

I. IS YOUR CENTER INVOLVED IN WORKING WITH SCHOOL SYSTEMS?

_____ 1= Yes
2= No (If no, skip to question 7)

II. WHAT SERVICES DO YOU PROVIDE TO SCHOOLS IN YOUR CATCHMENT AREA? PLEASE LIST ALL SERVICES YOU PROVIDE, SUCH AS COUNSELING, TEACHER TRAINING, RAP SESSIONS, CLASSROOM PRESENTATIONS, MATERIALS, ETC.

(1) _____
(2) _____
(3) _____
(4) _____
(5) _____
(6) _____

III. WHICH SERVICES ARE MOST OFTEN REQUESTED? FOR EACH SERVICE, WHAT ARE THE MOST COMMON TOPICS OR ISSUES?

	SERVICE	TOPIC
Example Response:	Rap Sessions	Communication, Sex, Drugs
(1)		
(2)		
(3)		
(4)		
(5)		
(6)		

IV. WHAT GRADES (OR GRADE TEACHERS) DO YOU WORK WITH, ~~MOST OFTEN~~? (CIRCLE APPROPRIATE GRADE LEVELS).

Grade Levels

K 1 2 3 4 5 6 7 8 9 10 11 12

V. HOW MANY SCHOOLS ARE IN THE CATCHMENT AREA SERVED BY YOUR COMMUNITY MENTAL HEALTH CENTER?

	Public	Private
Elementary Schools		
*Middle or Junior High		
High Schools		

(Put a dash if school system does not operate middle schools or junior high schools).

VI. HOW MANY SCHOOLS DO YOU PROVIDE SERVICES TO IN YOUR CATCHMENT AREA?

	Public	Private
Elementary Schools		
*Middle or Junior High		
High Schools		

(Put a dash if school system does not operate middle schools or junior high schools).

VII. ARE YOU INTERESTED IN PARTICIPATING IN A STATEWIDE EFFORT TO PROMOTE MENTAL HEALTH EDUCATION* IN THE SCHOOL SYSTEM?

_______ 1= Yes
2= No
(If no, skip to qustion 11)

*Mental Health Education is defined here as helping students learn skills, such as values-clarification, decision making, assertiveness, conflict resolution, which will help them respond to stress, handle major life decisions, and form more satisfying interpersonal relationships.

VIII. IN WHICH AREAS OF DEVELOPING AND IMPLEMENTING A MENTAL HEALTH EDUCATION PROGRAM ARE YOU MOST INTERESTED? (CHECK APPROPRIATE ANSWERS).

(1) __________ Participating in the development of a curriculum for Mental Health Education.

(2) __________ Participating in the development of a training program for teachers.

(3) __________ Providing in-service workshops for teachers in your catchment area who request the Mental Health curriculum.

(4) __________ Making schools in your area aware of the program (once it is developed).

IX. WHAT TRAINING OR EXPERIENCE HAVE YOU HAD? (PLEASE CHECK ALL THAT APPLY AND LIST ANY SKILL AREAS WE HAVE NOT INCLUDED.

(1) __________ Values-Clarification.

(2) __________ Communication Skills (e.g. Active listening, behavior feedback).

(3) __________ Role playing.

(4) __________ Decision-making.

(5) __________ Self awareness.

(6) __________ Processing skills (the ability to analyze a specific learning experience and understand the learning that occurred in the experience and its more general applicability.)

(7) __________ Group leadership skills.

(8) __________ Behavior modification.

(9) __________ Other (specify) ______________________________

(10) ____________ ____

(11) ____________ ____

(12) ____________ ____

(13) ____________ ____

X. WHAT TRAINING WOULD YOU NEED TO BETTER PREPARE YOU TO PROVIDE IN-SERVICE WORKSHOPS FOR TEACHERS WHO REQUEST THE MENTAL HEALTH EDUCATION PROGRAM?

(1) ____

(2) ____

(3) ____

(4) ____

(5) ____

XI. WHAT PROBLEMS WOULD YOU ANTICIPATE IN IMPLEMENTING A MENTAL HEALTH EDUCATION PROGRAM IN THE SCHOOLS IN YOUR CATCHMENT AREA?

(1) ____________ No release time for teachers for training.

(2) ____________ Teachers not interested.

(3) ____________ School administration not interested.

(4) ____________ Teachers feel threatened by program.

(5) ____________ Parental resistance.

(6) ____________ Students not interested.

(7) ____________ School administration feels Mental Health Education not appropriate for school.

(8) ____________ Other (specify) ______________________________

(9) ____________ ____

(10) ____________ ____

XII. WHAT SUPPORT WOULD YOU ANTICIPATE IN IMPLEMENTING A MENTAL HEALTH EDUCATION PROGRAM IN THE SCHOOLS IN YOUR AREA?

(1) ____________ PTA.

(2) ____________ Overall support from parents.

(3) ____________ Student interest.

(4) ____________ Endorsement by school administration.

(5) ____________ Support from community agencies (Clubs, churches, civic groups, etc).

(6) ____________ Support from agencies (such as counseling centers) that could provide resources for teacher training.

(7) ____________ Support from other Mental Health programs in the community.

(8) ____________ Teacher enthusiasm.

(9) ____________ Other (specify) ____

(10) ____________ ____

(11) ____________ ____

(12) ____________ ____

XIII. GIVE A BRIEF DESCRIPTION OF YOUR RESPONSIBILITY AS A COMMUNITY MENTAL HEALTH CENTER STAFF PERSON (SUCH AS, PROVIDING MENTAL HEALTH EDUCATION TO GROUPS, PROVIDE CONSULTATION TO VARIOUS TARGET GROUPS, PROVIDE SCHOOLS WITH ASSISTANCE, ETC).

(1) ____

(2) ____

(3) ____

(4) ____

(5) ____

(6) ____

(7) ____

(8) ____

(9) ____

SURVEY OF PRIMARY PREVENTION EFFORTS WITHIN SCHOOLS

NAME ____________________ TITLE ____________________

CENTER NAME ____________________

I. WHAT SERVICES DO YOU PROVIDE TO SCHOOLS IN YOUR CATCHMENT AREA? PLEASE LIST ALL SERVICES YOU PROVIDE, SUCH AS COUNSELING, TEACHER TRAINING, RAP SESSIONS, CLASSROOM PRESENTATIONS, MATERIALS, ETC.

(1) ____________________

(2) ____________________

(3) ____________________

(4) ____________________

(5) ____________________

(6) ____________________

I. WHICH SERVICES ARE MOST OFTEN REQUESTED? FOR EACH SERVICE, WHAT ARE THE MOST COMMON TOPICS OR ISSUES?

	Service	Topic
Example Response:	rap sessions	sex, drugs
(1)		
(2)		
(3)		
(4)		
(5)		
(6)		

II. WHAT GRADES (OR GRADE TEACHERS) DO YOU WORK WITH? (CIRCLE APPROPRIATE GRADE LEVELS).

Grade Levels

K 1 2 3 4 5 6 7 8 9 10 11 12

IV. ARE YOU INTERESTED IN PARTICIPATING IN A STATEWIDE EFFORT TO PROMOTE MENTAL HEALTH EDUCATION* IN THE SCHOOL SYSTEM?

______ 1=Yes
2=No

(If no, you need not answer the remaining questions).

*Mental Health Education is defined here as helping students learn skills such as values-clarification, decision making, assertiveness, conflict resolution which will help them respond to stress, handle major life decisions, and form more satisfying interpersonal relationships.

V. IN WHICH AREAS OF DEVELOPING AND IMPLEMENTING A MENTAL HEALTH EDUCATION PROGRAM ARE YOU MOST INTERESTED? (CHECK APPROPRIATE ANSWERS).

(1) ______ Participating in the development of a curriculum for Mental Health Education.

(2) ______ Participating in the development of a training program for teachers.

(3) ______ Providing in-service workshops for teachers in your catchment area who request the Mental Health curriculum.

(4) ______ Making schools in your area aware of the program (once it is developed).

VI. WHAT TRAINING OR EXPERIENCE HAVE YOU HAD WHICH WOULD PREPARE YOU TO WORK IN THE AREAS CHECKED ABOVE? (PLEASE CHECK ALL THAT APPLY AND LIST ANY SKILL AREAS WE HAVE NOT INCLUDED).

(1) ______ Values-Clarification.

(2) ______ Communication Skills (e.g. Active listening, behavior feedback).

(3) ______ Role playing.

(4) ______ Decision-making.

(5) ______ Self awareness.

(6) ______ Processing skills (the ability to analyze a specific learning experience and understand the learning that occurred in the experience and its more general applicability).

(7) ______ Group leadership skills.

(8) ______ Behavior modification.

(9) ____________ Other (specify) ______________________________

(10) ____________ ______________________________

(11) ____________ ______________________________

(12) ____________ ______________________________

VII. WHAT TRAINING WOULD YOU NEED TO BETTER PREPARE YOU TO PROVIDE IN-SERVICE WORKSHOPS FOR TEACHERS WHO REQUEST THE MENTAL HEALTH EDUCATION PROGRAM?

(1) ____

(2) ____

(3) ____

(4) ____

(5) ____

COMMUNITY MENTAL HEALTH CENTER SURVEY REPORT

COMMUNITY MENTAL HEALTH SERVICES
FOR GEORGIA'S SCHOOLS

Report of a Survey of Community Mental Health Centers' Prevention Activities in Schools*

The public health model recognizes three methods for primary prevention: strengthening the individual's physical and mental health before health problems occur; altering his socio-cultural environment in a salutary manner; or removing the functional "disease agent" from the individual's surroundings prior to its contact with him. A strategy of primary prevention may of course include any combination of these three approaches. In particular, the Office of Prevention is very interested in promoting mental health in schools through a Life Skills Education program which embraces the first two methods of the public health model. Life Skills Education would help strengthen students' abilities to deal with stress and crises and at the same time would impact the social environment of the schools system. The Office recognizes that the community mental health center can have an important role in this effort.

In order to help develop a plan for primary prevention efforts in the schools, the Office has conducted a statewide survey of current community mental health center involvement with the local school systems. This survey assessed the following five areas:

1.) The types of services that schools most often request from CMHC's and the services that CMHC's are able to provide consistently to the school systems.

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*Office of Prevention, Division of Mental Health/Mental Retardation, Georgia Department of Human Resources, August, 1976.

2.) The educational grade levels that CMHC's most often work with and the proportion of public and private schools with which the CMHC's currently are active.

3.) The specific areas of interest of the CMHC's in aiding in the development and implementation of a comprehensive Mental Health Education program for the schools.

4.) The types of training that CMHC staff have had which would be useful in various phases of developing and implementing this Mental Health Education program, and the additional training the staff at the CMHC's feel they would require specifically to provide in-service workshops for teachers interested in the program.

5.) The problems and the sources of support that the CMHC staff expect in implementing a comprehensive Mental Health Education program in the local schools.

The surveys were distributed to the Prevention Coordinators of each CMHC. One form of the survey, which inquired about all of the areas mentioned, was to be given to the person who had primary responsibility for CMHC involvement with the schools. An abbreviated form of the survey covered areas 1, 3 and 4 fully and area 2 partially. These shorter forms were to be filled out by other people in the CMHC who may have had contact with the schools.

Responses were received from 24, or fully two-thirds of the 36 CMHC's. A primary school coordinator had been designated in 21 of these 24 CMHC's. An additional 26 CMHC staff responded on the abbreviated forms.

Where applicable, data are recorded in three ways. Responses are broken down by primary school coordinators, by other staff of the CMHC's answering on the abbreviated forms, and by the total number of staff reporting on both forms.

The rest of the report briefly discusses each of the five areas listed above.

I. CURRENT CMHC INVOLVEMENT WITH THE LOCAL SCHOOL SYSTEMS:

Twenty-one of the twenty-four CMHC's responding to the survey reported that they had designated a primary school coordinator. Of these twenty-one, nineteen had been in contact with the schools for a period of time sufficient to have established regular school programs.

Tables 1 and 2 show that both the services provided by the CMHC's to the schools and the services requested of the CMHC's by the schools can be grouped into the following six major categories:

1.) Activities with student groups.
2.) Evaluation and consultation activities.
3.) Teacher in-service training or teacher workshops.
4.) Direct Client Care.
5.) Activities with communities and parent groups.
6.) Provision of mental health resources (films, books, pamphlets, etc.).

Several important conclusions can be drawn from the data presented in these tables. First, in every category, the amount of service provided by the CMHC to the schools exceeds the amount of service requested of the CMHC by the schools. This difference is most marked in the area of teacher training, where four times as much activity is carried on as is requested, but is also significant in the areas of treatment and community/parent contact, where the difference is twofold. These figures indicate not only the ability of the CMHC's to fill so far the requests of the schools for service but also argue a considerable independence and initiative on the part of the CMHC's in carrying their ideas and programs to the schools.

Second, it is heartening to note that the single most important priority of the CMHC's school programs is teacher in-service training or teacher workshops. This is true for CMHC staff who have had the primary responsibility for coordinating services to schools and for other staff who have had less involvement with schools. Classroom presentations directly to the students and individual case consultation to teachers come in respectively a close second and third. This is especially interesting in view of the fact that the schools place teacher training a distant fourth in their order of priorities behind classroom discussions, teacher consultations, and counseling. This is reflected in the data of Table 7 and Table 8. Table 7 indicates that most of the obstacles expected by CMHC staff in implementing a Mental Health Education program in the schools center around teacher and administration reluctance or non-enthusiasm. Table 8 shows conversely that teachers themselves are the one group anticipated to give the least support to the institution of such a program.

Third, the primary school coordinators and the "secondary" school workers do not differ significantly as groups in the services they provide to schools except in the evaluation/consultation sphere where the primary workers tend to work more with specialized organizations such as Psychoeducational Centers and Special Education classes than do the secondary workers. On the other hand, the secondary workers have more day-to-day contact with the public/private school teacher and classroom in the way of consultation and observation/evaluation, respectively.

Finally, it may be pointed out that 20% of all workers had set up special direct client services such as those listed at the bottom of Table 1, again showcasing the initiative of CMHC staff.

TABLE I: SERVICES PROVIDED BY CMHC STAFF TO LOCAL SCHOOLS

	School coordinators listing activity	Percent	Other CMHC staff listing activity	Percent	Total staff listing activity	Total percent
1) Activities with student groups						
a) Classroom presentations	15	71	16	62	31	66
b) Rap sessions	6	29	1	4	7	15
2) Evaluation and consultation activities						
a) Consultation to teachers, administrators, etc.	12	57	17	65	29	62
b) Consultation to Psycho-Ed Centers	4	19	1	4	5	11
c) Consultation to Special Ed	2	10	1	4	3	6
d) Classroom observation and/or emergency evaluation	4	19	8	31	12	25
3) Teacher inservice training or teacher workshops	14	67	18	69	32	68
4) Direct client care						
a) Counseling	10	48	12	46	22	47
b) Therapy groups	1	5	3	12	4	9
c) Psychotherapy	1	5	0	0	1	2
d) Specific programs*	4	19	5	19	9	19
5) Activities with communities and parent groups	6	29	7	27	13	27
6) Provision of mental health resources	5	24	6	23	11	23

*Among those listed: Individual behavior modification; parenting courses; classroom engineering; school phobia clinic; classroom crisis intervention; joint day care, meetings with potential "drop-out" groups.

II. DISTRIBUTION OF CMHC SERVICE TO SCHOOLS BY GRADE LEVEL AND BY PROPORTION OF PUBLIC/PRIVATE SCHOOLS CONTACTED:

The charts in Table 3 indicate that both primary and secondary workers give more importance to reaching students in grade levels 7-12 than reaching lower grade students K-6, with the peak level of contact occurring at grade 7 and slowly declining thereafter.

Table 4 lists the data on the proportion of public and private schools contacted by CMHC's. Sixteen school coordinators were able to supply figures on public schools. Two hundred forty of 546 schools of elementary level, or 44% were contacted, as were 63 of 106 or 59% of middle schools, and 82 of 145, or 57% of high schools. These figures are consistent with the trend noted in Table 3.

Only 11 school coordinators had reliable data on private school contacts. Twenty of 192, or 10% of private schools were contacted.

TABLE 2: SERVICES REQUESTED BY SCHOOLS

	School coordinators listing activity	Percent	Other CMHC staff listing activity	Percent	Total staff listing activity	Total percent
) Activities with student groups						
a) Classroom presentations	11	52	13	50	24	51
b) Rap sessions	4	19	2	8	6	13
2) Evaluation and consultation activities						
a) Consultation to teachers, administrators, etc.	12	57	11	42	23	49
b) Consultation to Psycho-Ed Centers	1	5	1	4	2	4
c) Consultation to Special Ed	—	—	—	—	—	—
d) Classroom observation and/or emergency evaluation	4	19	6	23	10	21
3) Teacher inservice training or teacher workshops	6	29	4	15	10	21
4) Direct client Care						
a) Counseling	3	14	9	35	12	25
b) Therapy groups	1	5	1	4	2	4
c) Psychotherapy	1	5	—	—	1	2
d) Specific programs*	1	5	1	4	2	4
5) Activities with communities and parent groups	5	24	3	12	8	17
) Provision of mental health resources	4	19	3	12	7	15

*See Table I for details.

TABLE 3: DISTRIBUTION OF EDUCATIONAL GRADE LEVELS RECEIVING SOME FORM OF SERVICE FROM CMHC STAFF*

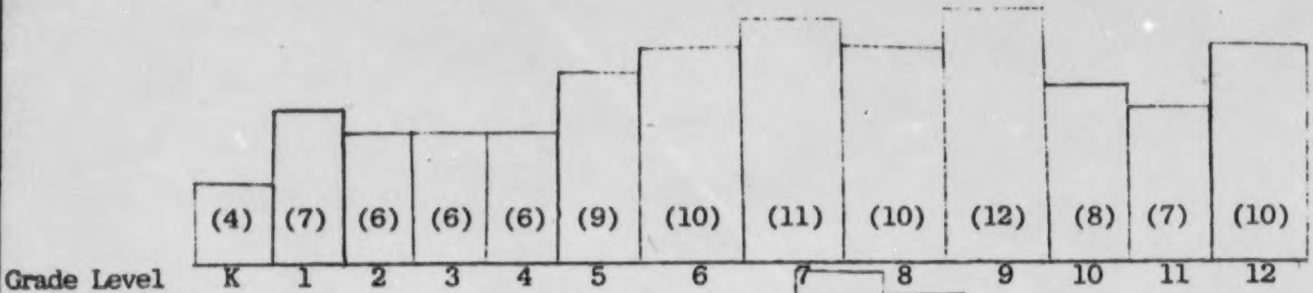

Figure 3.1 Responses of School Coordinators

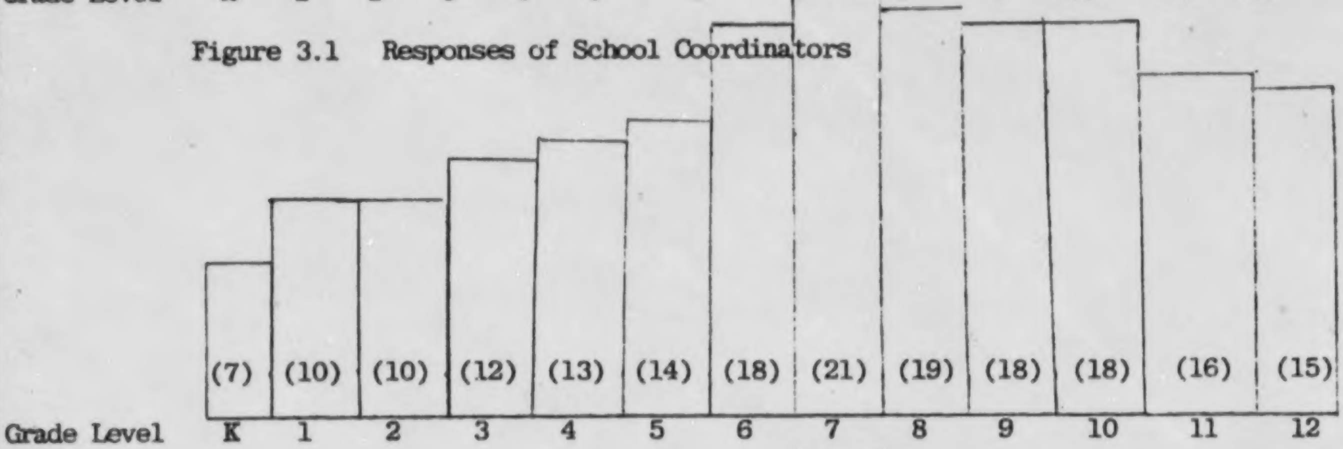

Figure 3.2 Responses of other CMHC Staff

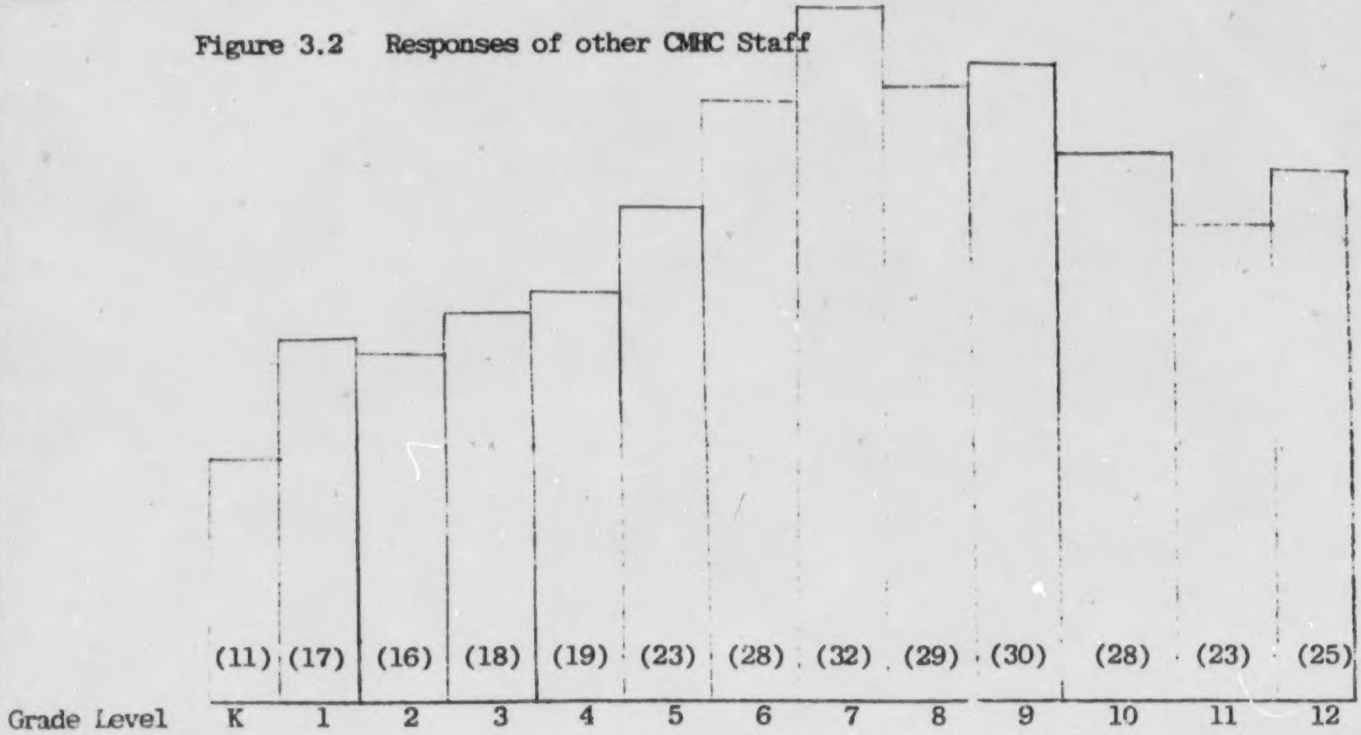

Figure 3.3 Responses of Total CMHC Staff

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* Numbers in parentheses refer to number of staff working with grade level.

TABLE 4: PROPORTION OF PUBLIC AND PRIVATE SCHOOLS CONTACTED BY CMHC's

4.1 Distribution of services to public schools (sixteen catchment areas)

	Total number of schools	Total number of schools serviced	Percent
Elementary schools	546	240	44
Middle schools, junior high schools	106	63	59
High Schools	145	82	57

4.2 Distribution of services to private schools (eleven catchment areas)

	Total number of schools	Total number of schools serviced	Percent
All schools	192	20	10

III. AREAS OF INTEREST OF CMHC STAFF IN DEVELOPING AND IMPLEMENTING A MENTAL HEALTH EDUCATION PROGRAM:

The Office of Prevention is currently working with the State Department of Education on the possibilities of developing and then implementing in the school systems a Life Skills Education Program. The purpose of this program would be to cultivate those interpersonal and intrapersonal skills which might enrich one's life and hopefully also have the effect of preventing future individual cases of mental health problems. The Office recognizes that such a program must be a cooperative effort to have a maximal opportunity to be successful, and welcomes the participation of the CMHC's in the program's formulation and implementation.

Four areas in which the CMHC's might assist in this project were assessed for the interest they held for CMHC staff. Specifically they were the following:

1.) Participation in the development of an activities guide for Life Skills for Mental Health.
2.) Participation in the development of a training program for teachers to prepare them to use the Life Skills material.
3.) Provision of in-service workshops for teachers in the catchment area requesting the Life Skills Program.
4.) Making schools in the catchment area aware of the program (once it is developed).

Primary school coordinators were greatly interested in both development of the activities guide and in teacher in-service workshops with 81% expressing willingness to participate. 71% were interested in the development of a teacher training program and 62% in carrying the program to the schools once developed.

Secondary school workers differed significantly in their participation preferences. They were, for example, just as interested in providing teacher in-service workshops, but less concerned about curriculum development, where only 35% expressed interest. They showed enthusiasm for helping to make the schools aware of the program once it had been developed, with 73% replying positively. Finally, 50% would participate in the development of a training program for teachers.

TABLE 5: CMHC AREAS OF INTEREST IN DEVELOPING AND IMPLEMENTING A MENTAL HEALTH EDUCATION PROGRAM

	School coordinators expressing interest	Percent	Other CMHC staff expressing interest	Percent	Total CMHC staff expressing interest	Total Percent
1) Participation in the development of an activities guide for Life Skills Program.	17	81	9	35	26	55
2) Participation in the development of a training program for teachers.	15	71	13	50	28	60
3) Provision of in-service workshops for teachers in the catchment area requesting the Life Skills Program.	17	81	21	81	38	81
4) Making schools in the catchment area aware of the program (once it is developed).	13	62	19	73	32	68

IV. CMHC STAFF TRAINING RELATING TO MENTAL HEALTH EDUCATION SKILLS:

The data in Table 6 reflect the fact that primary school coordinators feel competent in more mental health skills than do the secondary school workers; however, both groups have a high level of training in each of the eight particular skills assessed. Highest levels of training were in communication skills and role-playing; the lowest level of training was found in processing skills.*

CMHC staff were also asked to anticipate what additional training they might need to provide teacher in-service workshops on the Life Skills material. A few people responded that they needed more training in some of the particular skills listed in Table 6 such as Values Clarification, Communication Skills, Self-awareness, Group Leadership Skills, and Behavior Modification. Many stated that they acutely stood in need of good resource materials, whether they be books, pamphlets, films or other audio-visual materials. Some staff wanted more information on the objectives and contents of the workshops as well as the goals of a mental health education program. Others stated that they would need to know more about what teachers and students saw as needs in high schools at the present time before starting teacher workshops. Finally, some workers did not anticipate a need for additional training.

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* On the survey form "processing skills" were defined as:
the ability to analyze a specific learning experience and understand the learning that occurred in the experience and its more general applicability.

TABLE 6: TRAINING IN MENTAL HEALTH SKILLS EXPERIENCED BY CMHC STAFF

	Training of school coordinators	Percent	Training of other CMHC Staff	Percent	Total-all respondents	Total Percent
1) Values-clarification	14	67	9	35	23	49
2) Communication skills (e.g. Active listening, behavior feedback)	19	90	22	85	41	87
3) Role-playing	16	76	19	73	35	75
4) Decision-making	15	71	13	50	28	60
5) Self-awareness	14	67	17	65	31	66
6) Processing skills	8	38	11	42	19	40
7) Group leadership skills	15	71	18	69	33	70
8) Behavior modification	17	81	16	62	33	70
9) Other*	12	57	7	27	19	40

* Includes: family counseling; group processing; reality therapy; Parent Effectiveness Training (PET); Teacher Effectiveness Training (TET); learning disabilities; test interpretation; psychotherapy; assertiveness training; development of resource materials; parent education; child development; play therapy; marriage and family skills.

V. SOURCES OF PROBLEMS AND SUPPORT ANTICIPATED BY CMHC STAFF IN IMPLEMENTING A MENTAL HEALTH EDUCATION PROGRAM IN THE SCHOOLS:

Simply stated, CMHC staff saw that the problems they would encounter in attempting to implement a Mental Health Education program in the schools centered around teachers and administrators. In the first case, teacher enthusiasm was anticipated by only 33% of the workers whereas 38% of the workers expected no interest on the part of the teachers; 76% anticipated that lack of release time for teachers for training purposes would be a significant difficulty and 43% expected that teachers would feel threatened by the program. In the second case, 43% expected that the school administration would not be interested or would feel that mental health education was inappropriate for the schools (this was especially true in rural catchment areas), although 57% expected endorsement of the program by school administrators. Parents and students were viewed as sources of support for the program. Other community agencies that could assist in teacher in-service training or give other sources of support were expected by a majority of the workers to aid in the program's implementation. Finally, 24% of the workers anticipated a problem with CMHC staff time and/or funding.

TABLE 7: PROBLEMS ANTICIPATED IN IMPLEMENTING A MENTAL HEALTH EDUCATION PROGRAM IN LOCAL SCHOOLS

		Problems anticipated by school coordinators.	Percent of school coordinators anticipating problem.
1)	No release time for teachers for training.	16	76
2)	Teachers not interested.	8	38
3)	School administration not interested.	9	43
4)	Teachers feel threatened by program.	9	43
5)	Parental resistance.	4	19
6)	Students not interested.	2	10
7)	School administration feels Mental Health Education not appropriate for school.	9	43
8)	Other	10	48
	Problem with CMHC staff time or funding	5	24
	Teachers desire graduate credit for any extra training	2	10
	Desire by school personnel to participate in program development	2	10

TABLE 8: AREAS OF SUPPORT ANTICIPATED BY CMHC STAFF IN IMPLEMENTING A MENTAL HEALTH EDUCATION PROGRAM IN LOCAL SCHOOLS

	School coordinators anticipating support.	Percent of school coordinators anticipating support.
1) PTA	9	43
2) Overall support from parents	7	33
3) Student Interest	9	43
4) Endorsement by school administration	12	57
5) Support from community agencies (e.g. clubs, churches, civic groups)	10	48
6) Support from agencies (such as counseling centers) that could provide resources for teacher training	11	52
7) Teacher enthusiasm	7	33
8) Support from other Mental Health programs in the community	15	71
9) Other	4	19

CONCLUSIONS

According to a National report,* the bulk of CMHC consultation services to schools has been for diagnostic, evaluative, and other case-by-case types of service rather than involvement along a broader front of prevention services, such as teacher training and program types of consultation. The survey of Georgia's community mental health centers presents a somewhat different picture. While individual case consultation, evaluation and counseling are important services offered to schools, the majority of Georgia's CMHC's also give priority to prevention services, such as teacher training and group activities for students who are not necessarily experiencing problems. Moreover, CMHC staff were generally enthusiastic about developing and implementing a statewide mental health education program, which would provide an additional vehicle for prevention services to schools.

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*Mental Health and Learning: When community mental health centers and school systems collaborate, a joint publication of the U.S. Office of Education's Office for Nutrition and Health Programs and the National Institute of Mental Health's Division of Mental Health Services Programs, 1972.

APPENDIX C

LIFE SKILLS FOR MENTAL HEALTH STRATEGY STATEMENT

RESPONSES TO LIFE SKILLS FOR MENTAL HEALTH STRATEGY STATEMENT

LIFE SKILLS FOR MENTAL HEALTH STRATEGY STATEMENT

LIFE SKILLS FOR MENTAL HEALTH
STRATEGY STATEMENT

OFFICE OF PREVENTION
DIVISION OF MH/MR

INTRODUCTION:

The Office of Prevention of the Division of Mental Health/Mental Retardation proposes the development of a Life Skills Program (Mental Health Education) as a collaborative effort between the Division of Mental Health, the State Department of Education, and Community Mental Health Centers. The program would be available to local school systems upon request and to other youth groups (e.g. churches, YMCA, YWCA, Scouts, Youth Clubs, etc). This report suggests a strategy for developing and implementing the program. Briefly, the Office of Prevention would coordinate the development of the program, with broadly based input from educators, community mental health staff, other mental health workers, and professional organizations. The plan proposes that community mental health centers coordinate implementation in collaboration with local school systems. After initial implementation on a pilot basis, supported by the Division of Mental Health, the teacher training could become a reimbursable service paid for by local school system staff development monies.

The Life Skills Program, along with selected other primary prevention and early intervention efforts, is proposed as a major focus of the Office of Prevention for a two-year period (1976-78). At the end of this period, the program would be primarily locally based, with technical assistance from the State.

Also, during this two-year period, the Office of Prevention will be establish-

ing a comprehensive prevention plan, including Life Skills as one component. The comprehensive plan will broaden the scope of the Office's prevention activities to include the reduction of mental retardation and to include approaches which intervene in the various societal systems, as well as approaches aimed at individuals.

Prevention, and particularly the distinction between primary prevention and intervention, has long suffered the lack of a clear and widely accepted definition. For the purposes of this discussion, "Prevention is any organized activity affecting one or more people in such a way that future dysfunctional consequences do not occur or are less severe".

Under the broad concept of prevention, there are three areas of activity:

1) Mental Health promotion - these activities are directed toward the general population to enhance their ability to reach maximum potential and to strengthen their resources for handling stress and crisis. Promoting positive Mental Health reduces the occurrence of Mental Health problems.
2) Primary Prevention is the first line of attack with populations (or the systems in which they live) at risk for developing Mental Health related problems. For example, we know that a large number of people who seek treatment for drug and alcohol problems felt isolated and uninvolved as kids. They were not trouble makers, but rather were so passive and unassertive that most teachers and classmates would not remember them. Primary prevention could include finding ways to get these young people involved in life and encouraging their classmates to support rather than reject the children at risk. Primary prevention of Mental

Retardation, for example, includes reducing the conditions of pregnancy and delivery that are highly associated with mental retardation at birth.

3) *Early intervention activities are directed toward those people who are currently experiencing early indications of a problem, or toward the systems of people (school, classroom, employment situation, family, etc) that are creating a problem-producing environment. The purpose of early intervention is to minimize the impact of the problem, to prevent increasing severity, and to restore people to normal functioning.*

The Life Skill Program is for the most part, a program of Mental Health promotion, but it makes significant contributions to primary prevention as well. By enhancing the mentally healthy functioning of its audience, it fosters a supportive climate for members of the audience who are at risk or are beginning to experience problems. It makes it easier for these people to identify their problems and to seek help before the situation intensifies. For this reason, it is important to make a range of prevention services available to the people who participate in the Life Skills Program.

THE OFFICE OF PREVENTION:

In 1975, the Division of Mental Health/Mental Retardation published "A Four-Year Plan for Progress in Mental Health, FY'76 - '79". The Comprehensive Plan outlines five major long-range goals, each specified by four-year goals and objectives. The need and priority for prevention is stated clearly in Long Range Goal No.2: "To prevent or reduce the occurrence of Mental Health problems, and the degree of disability which may result". Under this goal, the Plan authorizes specific responsibility for prevention services within the Division: (Objective No. 2.3.1) "To designate clearly within the Division of Mental Health one person to serve as coordinator and developer of preventive servcies". Similarly, it authorizes that a State Plan be developed for providing preventive services through mental health programs (Objective 2.3.2).

The 1976 Session of the General Assembly passed the Mental Health Services Act (Act Number 1136) which created the Office of Prevention by law. Under Section 88-603, the law states that "The Department (of Human Resources) shall assign specific responsibility to one or more identified units of the Department for developing a coordinated program of research, education and service dealing with all aspects of prevention of mental disability...."

In February, 1976, the Division of Mental Health/Mental Retardation established the Office of Prevention as an Office of the Division, with responsibilities for reducing the occurrence of mental retardation, alcohol and drug problems and other mental health related problems. Staff include the Director, Assistant-Director for Primary Prevention, Assistant Director for Early Intervention, Telephone Information Specialist, and a full time consultant with specific responsibility for the DUI (Driving Under the Influence) school program.

LIFE SKILLS EDUCATION —WHAT IS IT? HOW WILL IT WORK?

Definition: Life Skills Education is defined here as an opportunity or process for learning basic intrapersonal and interpersonal skills which help a person handle stress, respond to major life decisions, and form more satisfying interpersonal relationships. These skills are basically the same skills that many mental health helpers use and teach when they work with people in temporary crises. The important intent of this program is that these skills can be taught more widely as an educational experience rather than as a therapeutic experience. Therefore, people will be better prepared to take responsibility for their lives and handle situations before they become crises. The educational process should provide an opportunity to develop and practice skills rather than just learn about mental health concepts.

Intrapersonal Skills concern the person's ability to deal effectively with himself--to know his needs and his values and to handle his feelings. The goal of intrapersonal skill development is to enable the learner to begin to trust himself; to accept his feelings as legitimate and to look to himself for answers to personal decisions. The specific objectives include:

1) Self awareness - the ability to discriminate feelings, to clarify personal values, needs and goals.
2) Self acceptance - appreciating personal strengths, limitations and resources.
3) Self determination - the ability to explore options, make choices (decisions) and evaluate consequences in terms of meeting personal needs.
4) Knowing reality and anticipating future events that are likely to occur (e.g. leaving home, marriage, retirement, death).

Interpersonal Skills concern the person's ability to relate to others. The goal of interpersonal skill development is to enable the learner to accept responsibility for his life, to accept his ability to play an active role in setting personal directions and to negotiate with people who touch his life in important ways. Specific objectives include:

1) Communication - the ability to listen and to respond with empathy, warmth, genuineness and concreteness; understanding of interpersonal transactions.

2) The ability to analyze specific experiences and understand the learning that occurred in the experiences and its more general applicability.

3) Personal Assertiveness - the ability to stand up for oneself, to let others know where one stands in a situation and to express feelings and needs to protect personal rights.

4) The ability to resolve conflicts and to negotiate.

5) Emotional involvement with others.

Rationale: In our rapidly changing and highly mobile society, people no longer receive consistent messages concerning what is an "appropriate" response to a situation, what are "appropriate" sex roles, what is "marriage", what is "single", what are important values, etc. The result is that more than ever individuals must struggle to find these answers for themselves and learn to accept the fact that the answers may change often. The struggle is more acute today than it was in the past. There is a need for different "life coping" skills to handle a more complex world. The value conflicts, role confusions and other sources of stress resulting from our highly pluralistic society have resulted in increasing numbers of people being in crises and seeking help through the "treatment" system. Many have sought their own solutions through drugs, alcohol, suicide and other self-defeating behavior.

Georgia's mental health professionals estimate that 10-15% of the State's pupulation can expect to seek help for mental health problems at sometime in their lives. During the fiscal year, 1974, 82,000 persons in Georgia were served by the State's public mental health system.* How many more have been served by private mental health professionals and hospitals. Moreover, these statistics reflect only reported problems. There are a number of symptoms of increasing stress among the general population, many of whom never enter a "treatment" system and therefore, never show up in the numbers that indicate the magnitude of mental health-related problems. For example, it is estimated that at least 50% of the physical complaints presented to physicians are primarily of emotional origin. Over 70% of the prescriptions written are for psychotropic drugs (tranquilizers, sleeping pills, antidepressants, etc.).*

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*These figures are taken from Georgia's Four Year Plan for Progress in Mental Health FY'76-'79. The 82,000 figure reflects mental and emotional disorders and alcohol and drug problems. It does not include mental retardation.

There are more dramatic indications of increased stress in our society. During the last 20 years, the suicide rate among young men and women between the ages of 15 and 24 has risen by more than 250 per cent.** The National Institute on Alcohol Abuse and Alcoholism estimates that there are over 9 million alcoholics in this country, and increasing numbers of alcohol problems are occurring among the young. The divorce rate has more than doubled since 1960.*** The jump is dramatic compared to the 20-year period from 1940 to 1960 where the rate increased only slightly. While divorce *per se* is not necessarily a mental health problem, it does generate anxiety and depression for some and it is indicative of the stability—or lack of stability—in a society. In Georgia, nearly 38,000 young people were reported to the courts for status offenses, behavior such as running away from home, which would not be

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*Kenneth Kenistone, "Heads and Seekers: Drugs on Campus, Counter Cultures and American Society", *The American Scholar*, 38;L, p.97.

**Interview with Dr. Hubert Hendin, "Suicides Rise 250 Per Cent", Atlanta Journal and Constitution, August 17, 1975.

***U.S. National Center for Health Statistics.

considered an offense if exhibited by an adult.* For some young people at least, running away and truancy are responses to personal or family problems that have reached a crisis state.

The money we spend each year in this country for the treatment of mental health problems is startling. Data for the U.S. show that we spend $37 billion each year not including expenses for the treatment of alcohol and drug problems or for mental retardation.

Life Skills Education is only one of a number of activities which would help reduce mental health related problems. It is not presented as a prevention program for severe disorders, nor is it presented as a replacement for counseling for people who are in temporary crisis. Rather, it is presented as an activity for strengthening people's personal abilities and resources to build more satisfying lives, to reduce the potential for crises in their lives and to more effectively deal with crises that arise and can lead to anxiety, depression and possibly to alcoholism, drug abuse, suicide and other problems. It can help people anticipate and prepare to handle stressful situations they are likely to encounter, such as leaving home, marriage, death, retirement, interpersonal conflicts and separation. It is a way of providing the needed attention to the countless numbers of people who may not visibly suffer from severe psychological problems but who nevertheless fall short of their developmental and learning potentials. This is one component of a comprehensive prevention program and an important responsibility of the total mental health care delivery system.

LIFE SKILLS PROGRAM FOR SCHOOLS:

Because of their daily influence upon children, the school systems of the State are strategic agencies for primary prevention in mental health. Everyone must attend school for at least some portion of his or her life. Therefore, the schools are a logical choice for reaching tomorrow's adult population. Unfortunately, for this very reason, each time a new social crisis arises (e.g. "the drug problem") the school is asked to introduce a new educational program to remedy the situation. Life Skills Education would alleviate some of the crisis programs and fragmentation by combining a number of issues and skills in one program

The task of public education, as stated by parents and educators alike, is the total development of the child - emotional as well as intellectual. Several years ago, the Georgia State Department of Education conducted a survey to determine the aspirations of the State's public for education. When the public was asked to rank order a listing of possible goals, the results were as follows:

Students should possess the ability to:

1) Understand and respect oneself.
2) Respect others.
3) Read, write, speak and listen.

Similarly, the goals for education of the State Department of Education and of the State Board of Education reflect concerns for social and emotional development. The Georgia State Board of Education says that as a result of public schooling "...the individual possesses an understanding of and respect for himself--his abilities, interests, values, aspirations and limitations--and uses this understanding to set personal goals."

More importantly, the students themselves are voicing a strong request for help in dealing with the issues and conflicts they face in growing up. In March, 1976, the Georgia Congress of Parents and Teachers (PTA) sponsored a workshop for over 60 junior high and high school students from across the State. The purpose was to hear what young people had to say about health education--and particularly to listen to the concerns they would like to include in school health education classes. Students divided their concerns into four areas: Social Health, Mental Health, Physical Health, and Environmental Health. They gave overwhelming priority to Social Health and Mental Health. Some specific concerns included: how to deal with failure and lack of trust, how to know and accept myself, dealing with peer pressure, dealing with competition, family relationships and conflicts, learning to cope with depression, rejection and life in general, and communication - especially with parents and teachers.

Although education has stated its responsibility for students' intellectual, emotional, and physical development, most of the attention has been given to intellectual and to some extent to physical development. The schools do influence a child's emotional development, to be sure. Most often it is not by conscious design, but rather by chance. The State Department of Education states in its brochure, "Missions" (p. 8): "Educators have found that the view a student holds of his own worth is closely related to his ability to succeed in school and in life. School curricula, however, often do not reflect this concern. Georgia schools should develop specific programs to allow students to improve their self concepts".

In states where mental health education has been introduced in the school system, the results have been very promising. In North Carolina, the State Department of Public Instruction has developed a "Life Skills for Health--Focus on Mental Health" K-12 curriculum guide. After two years, the "Life Skills" material is now in use in more than 50% of the 147 school systems in that state. The material is provided to schools only upon request and only if the schools agree to allow their staff to participate in specific training in the use of the material. A sample of 205 teachers, representing all grade levels and several geographic areas, participated in an evaluation of the material. Teachers reported frequent use of the material and intent to use the material more often. They also reported a number of positive changes in their students:

> Three-fourths of the teachers said their students were (1) better able to identify, understand, discuss and deal with their own feelings and the feelings of others; (2) better able to communicate with the teacher and with other students; more confident of themselves.
>
> One-half to three-fourths of the teachers said their students were (1) more able to identify personal values; identify alternative solutions to their own problems, and more skillful at decision making; (2) more able to recognize causes of behavior; (3) more willing to participate in classroom activities, better able to work in small groups, more positive in attitudes toward their peers.
>
> One-third to one-half of teachers said their students were (1) causing fewer classroom discipline problems; (2) more positive in their general attitude toward school; (3) more productive in their school work.

The public school system was established by a newly industrializing society characterized by primarily rural, parochial communities. It served an important function of teaching kids about the past and preparing them with basic skills (the 3 R's) for the immediate present. Today's society is drastically different. Life Skills Education is an important way for schools to respond to a society that is growing more complex and more urban by helping to prepare students for a rapidly changing future.

STRAGEGY FOR DEVELOPMENT AND IMPLEMENTATION OF LIFE SKILLS FOR MENTAL HEALTH

Process for Developing Strategy

In the past, "prevention" in the Central Office of the Division of Mental Health/Mental Retardation has been a fragmented effort. Most of the effort was concentrated in the Alcohol and Drug Section and in the Office of Child and Adolescent Services. The need existed for a prevention program with activities directed at all mental health-related problems, comprehensive in scope. When the Office of Prevention was created with responsibilities to the entire Division of Mental Health/Mental Retardation, the decision was made to begin with one statewide mental health promotion/primary prevention effort and one statewide early intervention effort, with well developed strategies for each. This represents the strategy for the initial primary prevention effort:Life Skills Education. At the same time, the Office plans to map out an overall strategy that will encompass the two initial efforts along with a variety of activities needed (1) to provide understanding and support for the field of prevention and (2) to make prevention a practical, effective activity rather than just a philosophy.

This strategy was developed first in outline form for review by appropriate people within the Division of MH/MR: the Director of the Alcohol and Drug Section, the Director of the Division, Members of the Prevention Committee of the Division, and the Prevention Subcommittee of the Governor's Alcohol and Drug Advisory Council.

This draft represents a first effort to fill in the outline to submit the Office of Prevention's plan of approach for review and revision. This draft will be shared with the above agencies, the State Department of Education, Georgia Mental Health Association, the Governor's Council on Mental Health, DHR-Division of Physical Health, the State PTA, the Alcohol Advisory Council, Members of the Mental Health Consortium, the Directors of the Community Mental Health Centers and their personnel designated to work with the Office of Prevention. In many respects, this strategy statement will remain a working document rather than a final product. The Office of Prevention will continue to solicit widespread input and ownership.

Steps to be Taken (Objectives)

1) To establish a cooperative relationship with the State Department of Education:

The Life Skills Program will be a resource, available upon request, to local schools. It is important that the Division of Mental Health solicit the cooperation and involvement of the State Department of Education to insure that the program complements the efforts of public education and responds to the needs of local school systems. The Commissioner of the Georgia Department of Human Resources submitted the Division's proposal for the Life Skills Program to the State Superintendent of Schools. At the Superintendent's request, representatives from curriculum Leadership, Health and Physical Education, Guidance and Counseling and Staff Development are meeting with representatives from the Office of Prevention and Community Mental Health to proceed with the development of the Program. This Committee will be the working committee. At each step of program development, input will be solicited from a broadly based task force.

The liaison with the State Department of Education is to accomplish the following:

To develop a Life Skills Activities Guide available to teachers (see Objective #4).

To develop in-service teacher training program (see Objective #5).

To facilitate cooperative relationships between local school systems and Community Mental Health Centers whereby schools would contract for staff development in Life Skills Education from Community Mental Health Centers and teachers would receive inservice credit (see Objective #5).

2) To establish a relationship between the Office of Prevention and Community Mental Health Centers for the development and implementation of the program:

The Office of Prevention has contacted each Community Mental Health Center Director to ask him to designate a person or persons on his staff to work with the Office in the development and implementation of prevention strategies. Involvement of CMHC's will certainly not be limited to designated "prevention coordinators". Rather, these staff will be the primary contact people for the Office. The Office will survey the prevention coordinators to determine to what extent they are or would be willing to work with schools in their catchment area to implement the Mental Health Education program. A meeting will be held with the prevention coordinators to share the concept of "Life Skills Education".

The Office of Prevention will ask the CMHC Prevention Coordinators to assume responsibility in the following areas related to Life Skills Education:

a) To provide input in the development of the strategy (this working document), the leader's guide, and the teacher training program.

b) To contact local school systems to inform them of the Life Skills Program (see Objective #7).

c) To establish a collaborative relationship with local school systems and to provide inservice teacher training to schools that request the program (see Objective #6).

3) To establish a task force for Life Skills Education to provide input and support for program development:

A number of groups and individuals in the State are interested in, and often are working to implement, Life Skills Education. A broad based task force would help to accomplish two major purposes:

a) The task force would provide a vehicle for broad based input into the program as it is being developed. Copies of the leader's guide and training format would be shared at each stage of development and revised with consideration for the recommendations from the task force.

b) The task force would strengthen the potential of the program by unifying support.

The task force would involve Office of Prevention Staff, designated representatives from the State Department of Education, Members of the Division of Mental Health/Mental Retardation Prevention Committee, CMHC Prevention Coordinators, Health Education personnel from the State Division of Physical Health and District Health Offices, representatives from the Georgia Mental Health Association, and the Governor's Mental Health Advisory Council, teacher preparation personnel from colleges and universities, and local school system personnel, including teachers, principals, and staff development people.

4) To prepare Life Skills Activity Guide (Leader's Guide):

In actuality, four "leader's guides" will be developed for four age ranges: 5-8 years; 9-12 years; 13-15 years; 16-20 years. Each guide will give step-by-step instructions for structuring experiences to help the target group learn important inter and intrapersonal skills (such as communication and personal assertiveness) and to explore critical issues they are facing, especially issues and decisions that are sources of anxiety and stress. The guides will be resources for teachers, church groups and civic group leaders, youth group leaders and Mental Health professionals who are often asked to conduct "rap sessions" in schools and with other groups.

The guides will not attempt to structure a separate course requiring a special teacher and a set block of time. Nor will the experiences have to be followed in the order set by the guide, itself. Rather, the guides are resources for all teachers--whether their primary teaching responsibility be English, history, or social studies--and would be most appropriately used as part of a comprehensive Health Education program. In short, the experiences can be easily integrated as part of other regular classes.

The first step in preparing the guides will be to review the wealth of material and "guides" that already exist in the field of Mental Health Education. Much will be adapted from these. In states where similar program have been implemented, we will draw on their practical experiences to develop issues that have been overlooked and to improve the existing strategies for dealing with the issues and skills already identified.

The Prevention Office will solicit input on the development of the guides from teachers, school administrators, counseling personnel, youth group leaders, and staffs of community mental health centers, mental health and education state agencies, Georgia PTA, and mental health associations.

A brochure will be prepared to explain the concept of Life Skills Education and to describe the program.

5) To develop inservice leader's training program:

The "leader's guide" will be available upon request to teachers, youth group leaders, etc. However, it will be required that any one requesting the guide(s) attend an intensive one-day training session. Guidelines for participation in training will help to insure a commitment from participants and, in the case of teachers, from their school administration. (For example, only teachers who elect to participate will be invited).

The inservice training will be available through the Community Mental Health Center. At first, the program will be piloted in a selected number of CMHC catchment areas where the mental health centers already have established relationships with the schools and where the schools are eager to incorporate the program. Pilot areas will include a variety of settings. Approximately 10 CMHC's will be selected for pilot areas.

The Office of Prevention will ask each prevention coordinator in the CMHC's selected for the pilot to select a team of four to serve as trainers. Team membership is not restricted to CMHC staff; it might be drawn from expertise wherever it exists in the community. It is important that team members be highly skilled in providing training in mental health skills. It is also important that members who are not part of the CMHC staff be able to commit time from their responsibilities to their agencies when training workshops are scheduled. Team membership could be drawn from community counseling centers, CESA's (Cooperative Educational Services Agencies), crisis intervention centers, special projects, local school counselors, and staff development staff, etc.

The Office of Prevention will bring the teams together for a "training of trainers" workshop. A follow-up workshop will be scheduled, once teams have had the opportunity to conduct one or two inservice workshops. The follow-up workshop will identify problems that have been encountered, and explore ways to resolve them or minimize their impact.

6) To establish a cooperative relationship between community mental health centers and local school systems for teacher training in Life Skills Education:

From the State level to the local level, the Mental Health System and Educational System share a common concern for the optimal intellectual and emotional development of Georgia's children. In the past decade, several pieces of federal legislation* have set the stage for collaboration between education and Mental Health professionals in the treatment and prevention of emotional and learning disorders in school children. The federal legislation creating the Community Mental Health Centers' Program was designed to make mental health services more comprehensive and more readily accessible through a network of community-based facilities. A community mental health center, by definition and by mandate, can collaborate with schools to assist school faculties, children, and parents.

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*Title VI, ESEA (programs for handicapped children, and Title 1, ESEA (school sponsored programs for economically disadvantaged).

Collaboration between the Community Mental Health Center and the school system for Life Skills Education includes the following arrangements:

a) CMHC staff are available on request to meet with teachers, principal and parents to orient them to the program and to answer questions and concerns.

b) Teacher training and follow-up technical assistance are provided by the community mental health center to schools requesting the program.

c) Schools provide release time for teachers.

d) Training for the Life Skills program is written into local staff development plans. This allows school systems to use staff development funds to contract with CMHC's for training services.*

e) CMHC's could inform schools of other independent Mental Health-related workshops being offered in the area (e.g. values-clarification workshops, Teacher Effectiveness Training).

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*For a training program to be applied as certificate renewal for teachers, the training must earn senior college or graduate credit. This would have to be arranged with a local college or area teacher education service. In-service training can lead to certificate renewal if it is part of the system or CESA staff development plan which has been in operation and approved for at least two years. It may take some time to establish this level of collaboration. In the initial pilot phase, the program will be offered without need of a contract for funds from the school system.

7) To inform schools of the availability of the Life Skills Program and other related resources:

A number of steps can be taken to generate awareness of the Life Skills Program.

a) Community Mental Health Centers can contact the schools in their catchment area and send each principal copies of the leader's guides and explanation of the training program.

b) Community Mental Health Centers can contact CESA's in their area (in some cases, CMHC's will want to establish cooperative arrangements with CESA's for providing teacher training).

c) The State PTA has developed a slide/tape presentation on Comprehensive Health Education which will be shown in 16 District PTA workshops, as well as local PTA meetings. The purpose of the presentation is to generate support among local PTA's to express a need for Comprehensive Health Education in their schools. The program builds support for "Mental Health Education" as a vital part of Comprehensive Health Education. Where parents do become strong advocates for health education, community mental health center staff will be available as resources in developing the mental health component. The Life Skills leader's guides and training program will be available to schools that want to adopt it as part of their health education program.

d) The State Office of Prevention will request time on the program of Operation Bootstrap, a quarterly meeting of all local school superintendents.

SUPPORT FOR LIFE SKILLS PROGRAM:

When the Office of Prevention first proposed the idea of a mental health education program, the staff shared the idea with a variety of professionals. The Office staff has received active support from the Division of Mental Health/Mental Retardation, the Georgia Congress of Parents and Teachers, and the State Department of Education. The Governor's Drug Advisory Council supports the plan as a worthwhile prevention acitivity. In July, the Office of Prevention surveyed the community mental health centers to determine the extent to which CMHC's were already involved with schools, what services were being provided to schools, what people resources were available to help develop a program, and center staff's reaction to the idea of a life sills program. The returns to date show overwhelming support for the program and a willingness to actively participate in the development and implementation.

Moreover, the Division's four year plan and the Mental Health Services Act support the concept of mental health education as an important prevention activity. Under the four-year-plan, Four-Year Goal No. 2.2 is "To increase the proportion of Mental Health Services devoted to educating and training other deliverers of human services who, through their work with clients, may assist in early detection and prevention of Mental Health problems". An objective related to this goal (Objective 2.2.3) specifically sights the school systems for attention: "To develop in each Mental Health program consultation, training and direct services to schools and psycho-educational centers by July 1, 1976". The Mental Health Services Act outlines a number of services to be included in State and Area Plans. Among them is "Education Services to increase general awareness of services available, provide workshops and other forums for the promotion of the Mental Health of the citizenry and to increase the ability of the citizenry to resist mental illness and emotional instability".

The State Department of Education has proposed a plan for a series of health education workshops throughout the State, which in many ways, would lay the groundwork for the Life Skills Program. The workshops will begin in December, 1976. They will be one-day sessions for college professors in health education, school counselors and teachers with responsibility for health education, to make them aware of — and hopefully interested in learning more about— affective approaches to teaching (e.g. values - clarification, communication skills, etc). Staff from the CESA's and from the community mental health centers will be invited as resources. This will be an important step in building a resource network and in making more schools aware of and receptive to teaching approaches which facilitate students' emotional and social development.

EVALUATION:

Process Evaluation of Strategy

This strategy is a "working plan". For that reason, each step of the process is presented here only in skeleton form. An on-going process evaluation -- what action was taken, what was accomplished, what new or modified direction resulted -- will allow prevention staff to more fully develop each step of the strategy as new information is gained.

Evaluation of the Life Skills Program

The program itself will be evaluated in a number of ways:

1) Evaluation of training sessions.

 a) Teacher's subjective evaluations of the training they receive from the CMHC's.

b) Trainer's evaluation of teacher's competency development. (This will tie into requirements for local school system's staff development plans and teacher certificate renewal credit).

2) Teacher's evaluation of impact of program on students (i.e. is the teacher experiencing better communication in the classroom, fewer conflicts, more acceptance among classmates, more willingness to work out problems, less acting out behavior, etc.).

3) Student's evaluation of the program.

4) Measures of changes in students' self-concept, self-acceptance, anxiety, etc..

5) Unobtrusive measures:

   a) Fewer referrals for discipline problems.

   b) Decrease in absenteeism.

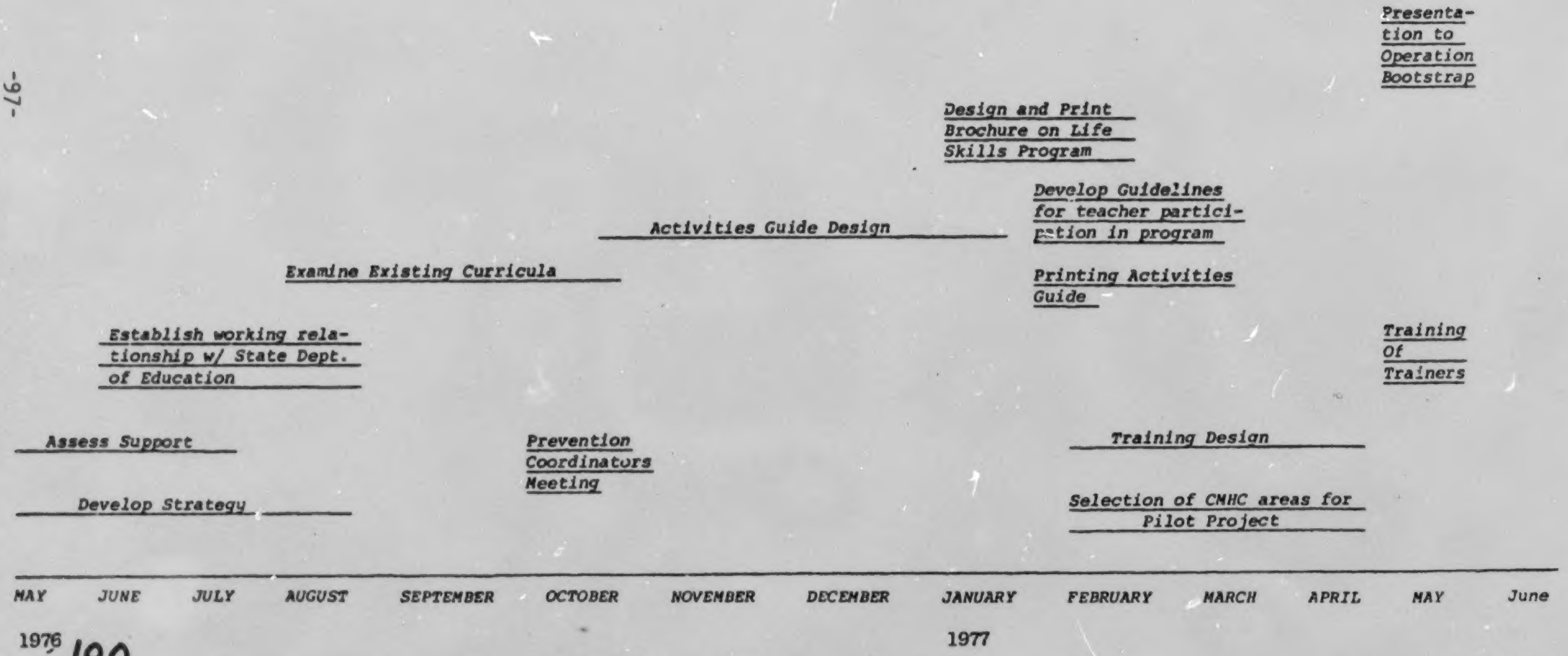
   c) Improved grades.

At first, there may be increased referrals for counseling, since the Life Skills Program is likely to make it easier for submerged personal problems to surface. In the long run, however, it is anticipated that the Life Skills Program will better enable people to handle problems before they get out of hand, and therefore to need counseling services less often or for shorter durations.

6) Cost effectiveness.

TIME LINE

FY'77


Presentation to Operation Bootstrap
Design and Print Brochure on Life Skills Program
Develop Guidelines for teacher participation in program
Activities Guide Design
Examine Existing Curricula
Printing Activities Guide
Establish working relationship w/ State Dept. of Education
Training Of Trainers
Assess Support
Prevention Coordinators Meeting
Training Design
Develop Strategy
Selection of CMHC areas for Pilot Project
MAY
JUNE
JULY
AUGUST
SEPTEMBER
OCTOBER
NOVEMBER
DECEMBER
JANUARY
FEBRUARY
MARCH
APRIL
MAY
June
1976
1977

TIME LINE

FY'78

(CMHC) Teacher Training Workshops

CMHC)
ontacts with schools/CESA's

Awareness Campaign--Statewide Dissemination through State Department of Education--Teacher Education Services

CMHC) Refine
eacher Train-
ng Workshop for
ocal workshops

Follow-Up Workshop for Trainers

Pilot Project Evaluation

ULY *AUGUST* *SEPTEMBER* *OCTOBER* *NOVEMBER* *DECEMBER* *JANUARY* *FEBRUARY* *MARCH* *APRIL* *MAY* *JUNE*

977 1978

RESPONSES TO LIFE SKILLS FOR MENTAL HEALTH STRATEGY STATEMENT

Thank you for sharing the draft form of your primary prevention program, "Life Skills for Mental Health." I regret that I found the form to be inadequate to enumerate the many philosophical, conceptual, and methodological problems contained in the proposal. Instead, I am attaching a copy of a review of the proposal which I asked our Regional Director of Training, to prepare. I would like to reiterate statement that our critical comments are offered not in an attempt to stifle or destroy the fledgling efforts of our new Office of Primary Prevention, but rather out of a conviction that the area of prevention holds too much promise for long range payoff to risk getting involved in the "life skills" program as the State's pilot effort.

questions the supportability of the project's basic assumption that there is a causal relationship between feelings and psychodynamics of children and their later life adjustment. Another reference on this issue is the work of the Joint Commission on Mental Health of Children, which did an exhaustive literature review on this subject, published in 1969 in the Handbook of Child Psychopathology, edited by Benjamin Wolman. Quoting from page 1271 of chapter 42, titled "The Predictability of Adult Mental Health from Childhood Behavior," we find the following:

> "In a thoughtful brief earlier research review, Lewis (1965) concludes: 'the continuity hypothesis, that emotionally disturbed children will become mentally ill adults, has received only mild research support. The extent to which a childhood predisposition to mental illness influences appearance of problems in adult life is not entirely clear, but it is apparently not a determining factor.' With two major exceptions our own more extensive research review generates the same pessimistic conclusion, similar to Freud's conclusion quoted in the introduction. The first major exception to this

> conclusion is that at least some forms of schizophrenia in adulthood are predictable in terms of biological disposition detectable in childhood and caused by a compound of hereditary and perinatal brain damage factors. The second major exception is that criminality and poor moral character (sociopathy and character disorders) are clearly predictable from a compound of family environment factors and from occurrence of overt antisocial behavior in childhood. One form of prediction is biological; the other is in terms of environment and overt antisocial or immoral behavior. In neither case is intrapsychic emotional disturbance a useful or basic aspect of the predictive picture."

Despite recent memo concerning the research design which will accompany this project, I am finding that the more I learn about it the more distressed I become. However, I will look forward to working with the prevention committee at the next quarterly conference, and am hopeful that each Consortium will give considerable thought to these issues prior to that time.

This is a response to two documents produced by the Division Office of Prevention: the draft Strategy Statement and the draft Leaders Guide for 5 to 8 year olds, Life Skills for Mental Health. In addition to minor comments about the content of the manual, I want to question both the appropriateness and the feasibility of the project as a whole. These critical comments are offered for consideration because I am convinced that the area of prevention holds too much promise for long range payoff to risk the proposed strategy of focusing on Life Skills as the State's pilot effort.

1. The proposed strategy is inappropriate because it ignores what is known about the prevention of mental disability in favor of a fuzzy strategy which at best has the virtue of sounding in general like a good idea.

   a. The project lacks a clear theory of intervention. In his 1976 Presidential Address to the American Psychological Association's Division of Community Psychology, Emory Cowen said: "If we are to gain some ground in primary prevention, some of the fuzz and mystery must be removed from the concepts to provide sharper, more operational answers to the question of what we, as mental health specialists, are best equipped to contribute. We must go beyond heartfelt, vocal support for the lyrical - but potentially nauseating - platitude of improving the quality of life." Both the proposed documents suffer, in my opinion, from an over supply of good intention, fuzz and mystery and a lack of any clearly articulated or supportable theory of intervention.

   Both documents abound with great leaps across levels of abstraction most of which don't land on solid ground. For instance we are told in the strategy paper that the project is intended to exemplify an approach to primary prevention. This is defined by tautology (at page 2) as "The first line of attack with population...at risk for developing mental health related problems" and by example in terms of what "we" are presumed to "know" about people who seek service for substance abuse problems, namely that they "felt isolated and uninvolved as kids". Primary prevention then "could include finding ways to get these young people involved in life...".

Leaving aside that what "we" know does not begin to support a causal relationship between number of friends or activities at school and substance abuse (though perhaps an uncited study exists which establishes some correlation), the life skills project is not clearly defined in terms of its possible effects even on the exemplified primary prevention goal. For instance, nowhere in the "helpful notes" for leaders is there a helpful note on working with the child who is withdrawn from the life skills class. Experienced teachers suggest that this is, in fact, a classroom problem (however tenuous its relationship may be to substance abuse or schizophrenia in later life).

Furthermore, we are told at pages 4 and 5 of the strategy statement that the program exists to teach skills to better prepare children to take responsibility for their lives (which, in passing, would seem to define the project as a mental health promotion activity, not a primary prevention activity, to cite the strategy statement's own rather odd distinction). However, and this represents another basic weakness of the proposed project, there is no reference in the leader's guide to any of the systematic strategies which do enjoy some support in the literature for increasing children's ability to relate positively to others in their school environments. Are the authors unaware, for example, of the work of Graubard and his associates or have they choosen, for some reason, to ignore it in favor of less systematic and less evaluable exercises?

When one tries to relate particular activities within the manual to "purposes" there is reasonably good fit. Trying to operationalize the purposes to plan evaluations of reliability (say nothing of validity) of the project is far more difficult. Connecting either to an articulated theory of prevention is beyond me Surely the project's theory of intervention does not lie in the unsupported (and as far as I know, unsupportable) statement that "Promoting positive Mental Health reduces the occurrence of Mental Health problems (capitals in original)".

In summary: (1) The project is at risk of failing to achieve its objective of preventing anything because it falls victim to all three of the conceptual problems noted by Zusman (1976) namely, that there is no clear and measurable definition of mental health advanced in the proposal; that the proposal seems to accept the assumption that mental health and mental illness are mutually exclusive when in fact this does not square with available evidence; and that mental illness can be affected by measures taken during the lifetime of the person who is the target of the measures whereas in fact most available (unproven) causal theories place importance on genetic endowment or pre-school development as determinative of a person's susceptibility to mental illness. (2) Both documents exhibit either an ignorance of the, literature of the field or a set of undisplayed choices to ignore the literature, which, in my opinion, is unconscionable. (3) The project is designed in a way that it cannot possibly meet the criterion of teaching the field something about prevention. Compare the research de design involved in other efforts (e.g. the Woodlawn Project (Kellam, et al, (1975) or the St. Louis Project (Glidewell, 1961)) with the almost unbelievably naive design offered on page 22-23 of the stragegy statement.

b. The project is approaching the wrong problem. Given that the Division has limited resources for prevention activities, responsible use of the money suggests that either it should undertake a research activity to discover a method of prevention (which this project is not) or it should invest in the area that has the highest probability of payoff. The primary prevention measures which have had clear impact on the occurrences of mental illness - namely treatment of pellegra and syphilis - are now a part of the province and practice of general medicine and public health. Other strategies of dealing with major mental illness and substance abuse do not demonstrate any positive effect on target conditions (though it may be possible to demonstrate impact on an hypothesized intervening variable such as for instance ability to make friends or control social anxiety). However, in the field of mental retardation a substantial and reliable body of knowledge exists concerning the cause of some conditions which result in retardation (Fotheringham and Morrison, 1976). I suggest that the office of prevention reconsider and begin its work where there is a possibility of real impact on severe disability since there is currently no systematic address to prevention of severe mental retardation in Georgia.

2. The proposed strategy is likely not to work because it ignores the most significant power groups in achieving change in school systems, namely teachers and principals. This is another instance of the apparent failure of the authors of these documents to consult the literature or to systematically consider the impacts of what they are undertaking. We are told at pages 12 and 13 that people within the mental health system agree that it is a good idea that school principals and teachers behave differently, that some members of the state's PTA agree that principals and teachers should behave differently, that some students think it would be good to know about how to live better with others, and that even some people in the Central Office of the Department of Education think it's a good idea that principals and teachers behave differently. However, it should be recognized that authority over what is taught and how rests with local school boards in law and with principals and teachers in classrooms in fact. Sarason (1972) provides an instructive chronicle of what becomes of the well intentioned mental health professional who tries to deal with a school system. He concludes that it seems possible to accomplish a little if teachers are actively on your side and far less than nothing without them.

The strategy paper offers us no light on how teachers themselves, and particularly the GAE, an extremely significant power group, have been systematically involved in developing the project. Some teachers would, I'm sure, like the idea. How many of them already have access to similar materials of much higher quality and training at least as good as that the Division could make available? A spot check of the manual with a very small number (5) of experienced teachers drew the comment that it was "Ok, but nothing new." and 2 reported recent inservice training with an apparently similar intent. The available documents tell us nothing of how systematically the need for such a project has been assessed in the field.

Further, it seems to me that in addition to those teachers who already are committed to the type of teaching suggested by the guide there are many who appear to share the Governor's concern with a return to basics (by which in his public statements he seems to mean the three R's) and a restoration of classroom discipline and order. While it could be true that a classroom that includes two half hours a week will experience a higher degree of order and will make better academic progress than one which lacks such a program, the burden of proof remains with the implementer to establish the connection.

Finally, even if the project were a reasonable activity for the Division, the amount of training time proposed is utterly unrealistic to establish reasonable levels of the skills required to implement the activities in the guide in any but the most rote manner. For instance, Brown (1974) describes a humanistic education program which required a year round support program for its teachers as a precondition of its success; Aspy (1972) reports a provocative set of studies establishing some relationship between children's academic skills and the level of interpersonal skills displayed in the classroom by teachers which required 40 hours of systematic training and an organized, continuous, supervision and followup effort for its effect (tests of less training time and/or less support remove differential outcomes).

In summary, the Office of Prevention is either proposing that the Division spend its scarce prevention resources in developing one more handbook to lay on the shelf or it proposes a major change in the culture of our schools. If they propose to change our state's classrooms, they must answer better than they have what mandate the Division has to be involved with school curriculum and why they feel that this guide represents the best strategic choice to make such a mandated intervention.

3. Though I do not feel the project as a whole is worth doing, I offer the following comments specific to the draft leader's guide for five to eight year olds.

   - The age span (5 - 8 years) for the guide raises some internal difficulties. Five and six year olds have different capabilities and need different types and degrees of structure than seven and eight year olds. At least the exercises should be reworked to illustrate this application in different age groups.

   - Many of the activities suggested by the guide require a high level of verbal skills and substantial ability to write. To be useful across the range of abilities in schools the manual needs to describe many more alternatives for children with more limited expressive skills.

   - The guide presumes that teachers have a higher level of interpersonal skill than may be warranted. For instance, manual exercises need to be adapted: it is a rare six year old who can name something that happened on the playground that positively affected his self image. The manual needs more attention to developing sequences of questions which are responsive to different age children. Furthermore, the skill the manual calls "Listening for Feeling" is more difficult for those who don't already have it to master than the manual would suggest.

- The section entitled "Helpful Notes" is apparently taken from a source unrelated to the age group (e.g. few eight year olds will be reading Romeo and Juliet and discussing the issues involved in dating someone your parents don't like). It also fails to provide much help with the real world of many classrooms. For instance, the suggestion that teachers stating their own feelings to disruptive children "may take a day but works surprisingly well" is ludicrous to anyone who has ever taught a class of real children. More seriously, the guide avoids a central problem: one rationalization offered for the department's involvement in this project is that it will increase children's and teacher's awareness of problems and their willingness to seek and use help; however the guide says that the project intends "to prevent problems, not treat them." and that the leader is not responsible for solving problems. Children however may not have read the manual and may present real life problems. The guide needs to address this possibility in clear terms.

- Though the first section of the guide suggests that "observable changes" will result from use of the suggested activities it fails to enumerate what these changes are to be and how they might be pinpointed and measured should anyone be interested in an empirical test of the program's reliability.

- There is a further confusion between the "half hour twice a week" time frame suggested for the activities and the apparent requirements of many of the activities.

All of these small points reflect an apparent lack of systematic thinking on the part of those who prepared the guide. The cut and paste approach that seems to have been taken to developing the guide is irresponsible from the point of view of instructional design and makes the manual less effective than many comparable volumes which are easily available at no development cost.

I am writing in response to your memorandum of January 3 and to an earlier memorandum to you from which raises your concerns about the "Life Skills For Mental Health" program. I would like to outline the points of issue as I see them.

1. As I read your memoranda, the major point of difference that underlies the issues you raise is one of "philosophy of prevention" and consequently where the Office of Prevention's priorities should lie. Your belief is that our limited prevention resources should be spent on the severe, psychotic mental disorders which require institutionalization in our treatment facilities. The "Life Skills Program" is not addressing the prevention of schizophrenia or other severe disorders. It is concerned with the prevention of mental health problems as a result of situational crises (going to a new school, family conflicts and divorce, death) or developmental crises (e.g. growing independence and responsibility) which confront a large segment of the "normal" population. Although these problems may not result in the severe disability we see in psychotic disorders, they do, by viture of the large number of people experiencing the problems, cause problems in social adaptation and lost productivity, and drain treatment dollars for counseling services. For example, people experiencing divorce show up frequently in many of our "social casualty" statistics such as accidents, suicides, alcohol and drug problems, and are significantly more likely to request help from a mental health facility than "non divorcing" people. Another example — the Woodlawn Project which you sighted in your memo shows that children who change schools score significantly lower on the "Social Adaptation Status" scale than children who do not move, and are more likely to have adjustment problems as reported by their teachers.

I am not sure how to resolve this difference of philosophy. There are mental health professionals and research studies that support your position and there is a large growing body of mental health professionals and research to support prevention strategies like the Life Skills Program.

I would like to make one point very clear. The Office of Prevention is not opposed to mounting activities related to the prevention of schizophrenia or mental retardation. As you know, the only program funding we have at this time is alcohol and drug money. We must be able to relate our activities supported by this money to the prevention of alcohol and drug problems. We welcome help from GMHI and the Northeast Consortium to develop proposals and secure funds for the prevention activities you advocate.

2. Another point of disagreement centers around supporting research for the Life Skills Program. There does not exist, at this time, long term evaluation studies which show that young people who experience "affective educational programs" (such as the Life Skills Program) have fewer mental health problems related to situational or developmental crises as they grow up. For one thing, these types of programs have not been popular long enough to allow a generation to grow up. Secondly, that type of research is very expensive; I would like to know of funding resources that would support a 20-year evaluation follow-up.

There is, however, a wealth of evaluative research that documents the immediate benefits to young people (and to school systems) from participation in the types of activities included in the Life Skills Program. Studies consistently show that children improve in self concept (as measured by a variety of scales), have more satisfying interpersonal relationships with peers and teachers, are better able to handle feelings (i.e. can identify and express true feelings rather than camouflage them through acting out behaviors), and can more clearly identify their personal values. Another consistent finding is that students participate more in regular subject activities and grades improve. Similarly, teachers report more class enthusiasm, fewer discipline problems and reduced absenteeism. So how do we conclude from these results that a Life Skills-type program would reduce mental health problems? Until the long term evaluation is possible, we are making some logical assumptions. Poor self concept, feelings of incompetence, family conflicts, poor interpersonal relationships, and value confusion are reported by mental health professionals as rather consistent characteristics of clients who seek help with situational crises and alcohol and drug problems. The therapy process with these clients is generally one of helping the individual accept himself and value himself and teaching him skills in interpersonal communications and negotiation to help him relate more effectively to significant people in his life. The assumption underlying affective education is that this process would be extremely beneficial to people before they're in a crisis. If, for example, a person learns good communication and negotiation skills and personal assertiveness, he is better able to respond productively to family conflicts that arise, that sometimes build to crisis proportions and result in divorce, children running away from home and severe emotional trauma.

3. Another issue that you raise is whether or not the mental health system has any business developing programs for schools. First let me say that the Life Skills Program has been a joint effort with the State Department of Education. So, educators are taking an active role in developing this program for their own system. Secondly, the goals and objectives of the State Department of Education and the State Board of Education are consistent with those of the Life Skills Program. The State Department of Education states in its brochure, "Missions"(p.8): "Educators have found that the view a student holds of his own worth is closely related to his ability to succeed in school and in life. School curricula, however, often do not reflect this concern. Georgia schools should develop specific programs to allow students to improve their self concepts."

   The State Board of Education is currently revising the requirements for high school graduation to include "life role competencies." Deede Sharpe, Director of the Division of Competency-Based Education and the staff person working with the State Board, wrote in a letter after reviewing the Life Skills material, " . . . I am most impressed with the extent to which (the Life Skills Project) shares the goals of existing State Department of Education efforts and of the new competency-based policy recently passed by the State Board." She specifically requested that mental health work with her Division in the development of the new student competencies for high school graduation.

   Thirdly, in the past decade, several pieces of federal legislation (Title VI, ESEA and Title I, ESEA) have set the stage for collaboration between education and mental health professionals for the treatment and prevention of mental health problems in school children. Similarly, the legislation creating the CMHC program calls for collaborative efforts between schools and community mental health centers in treatment and prevention.

   This summer, we surveyed Georgia's area mental health programs to determine their involvement with schools and interest in the Life Skills Program. Twenty-four centers responded. Nineteen centers had established programs with school systems. Their single most important priority for services to schools was teacher in-service training.

4. I don't want to close without responding to the specific comments relating to the draft leader's guide at the end of letter. The criticism concerning the verbal skills required for many activities is well taken. We will work to make this and other guides more responsive to less verbal children. We are also aware of the limitations of the teacher training session that is part of the program. However, we see this program as only a beginning. We do not propose that this program alone is a sufficient prevention program. But it is a first step in working with schools to respond to the mental health needs of children. I don't think we would be very successful if we proposed a complete revamp of the school system as the first step. If teachers and principals become comfortable with this program, we anticipate that they will request additional training. This has been the case in other states where

similar programs have been implemented. For many school systems, the activities and teacher-student interaction proposed by the Life Skills Program is a new experience. Their introduction must be simple and gentle.

We have been in contact with the Georgia Association of Educators and with a number of principals, teachers, and guidance counselors in developing the guide. The State Department of Education distributed the guide for input. The reaction from local school people has been overwhelmingly supportive. A number of teachers tried some of the activities and were very enthusiastic. As we decide with the community mental health centers which areas will be a part of the pilot phase, those centers can elicit specific involvement with the remaining drafts from schools that are likely to participate.

Again, let me say that we appreciate your interest in prevention. I hope that we can work together to develop new prevention activities.

Thank you for sharing the draft of information related to the "Life Skills for Mental Health" Program. I have circulated it to most of our staff who have been relating to schools. Unfortunately, the document has not made its way to the alcohol or forensic staffs and they too are involved in activities in schools in our six-county area. However, if they have any comments once they have read the material, I will be happy to forward it to you.

The concensus from the staff in this center is basically that of support. We like the ideas presented, agree with the need for a mental health education curriculum and generally are pleased with the interest in prevention. Basic concerns, questions and negative comments generally related to the mechanics of the proposed program. Comments:

(1) A primary concern, evident on the first page of the draft, is the control and development from the state level. This is already a problem with school systems we deal with "listening" to Atlanta, but not "hearing." The school systems will do what they want to do, no matter what the state department says. Therefore, much more imput must be recruited from the local school systems and the mental health centers.

A suggestion to combat the offensiveness of this being a state level idea would be to utilize the consortium areas from the development of a regionally acceptable program. It would be impossible to have imput from all areas of the state, but if confined to the consortium areas, the effort would be interpreted as more locally based and developed.

(2) Throughout the draft there is mention of teacher training being a reimuburseable service paid for by local school staff development funds. For five of my counties, this would be a service already provided by CESA. At this point, I can not comment on how CESA or the school systems might accept a change in their current agreement.

(3) In discussing the three areas of activity concerned with prevention, I see a need for involvment by the Mental Health Association, particularly with mental health promotion, and the Division of Physical Health, with reference to primary prevention and early intervention. I would also like to add that the home extension agents and 4-H Club Advisiors should also be tapped for their imput and their assistance. Nationally these people deal with mental health education as much as schools, reaching a population and age group that coincides with, and yet sometimes extends beyond, the classroom aged individual.

(4) When reviewing the "Strategy for Development Section", I was hit by the lack of imput from the local level again. The review committee in the Division and the Governor's office are for the most part "unknowns" to me. Therefore, I appreciate your efforts in circulating the draft to local level personnel, but continue to feel our imput was warranted before now. you mentioned to me that had been working on a committee with you and I feel comfortable in his imput. I would liked to have known others involved too.

(5) Looking at the program from a financial standpoint, and my center's budget, I would like to know what support can be anticipated from the Division in providing funds for CMHC staff travel during the development stages of the curriculum, guides etc. Local travel to sell the program in the school systems would be included in our regular budgets. But travel to committee meetings, etc. for local personnel could greatly hamper our operating budgets, especially those CMHCs who run extensive outreach programs already combating inflationary gas prices.

our discussions in Atlanta have reflected my past concerns. To a great extent, I am responding as the centers did in Kentucky when an Office of Preventive Programs was established. Then, as now the centers has been asked to assume another responsibility without increases in staff or monies. I'm sure we will pursue the "Life Skills Program" . . . and we'll grumble. However, my grumblings and that of my center director would be less had we had prior involvement....all the way back to the development of goals, objectives, etc. for the Office of Prevention. Therefore, please accept our desire to stay involved as positive interest and support.

Attached you will find a copy of a news letter from our local psycho-ed center. Please note the section on "Life Coping Skills."

Thank you for your thoughtful letter about the Life Skills Program. I want you to know how much I appreciate the interest you have shown in the Office of Prevention and the activities we are developing. I know at times you must feel that we don't hear what you're saying. But we do hear your concerns and want to respond to them as best we can, given the constraints we face.

I really hear what you're saying about local involvement from the beginning, when objectives are set and directions are chosen. I admit that we chose to mount two prevention programs without asking people in the field if these were high priority areas of activity for them. Rightly or wrongly, we made that decision because we felt that the survival of a state-level prevention function—and consequently the survival of state support for local prevention efforts--depended on it. We felt that we needed to have visible, operational prevention programs well on their way by the end of the first year of our Office's existence, so that we could point to "prevention" as program operation, and not just a nice philosophy. I guess the push of time kept us from asking for local-level input as much as we would have liked. This does not mean that we plan to continue single-handedly defining prevention and prevention programs for the State. We are meeting with a consultant now to plan a process for organizing input from state and local resources. We really see this process as a way of bringing people in at the ground level to help us define the role of the State Office of Prevention and the program directions we should pursue. In the meantime, we will have two prevention programs going to give prevention the active visibility it so desperately needs when legislators and policy makers are making their decisions.

In short, I can really appreciate what you're saying and agree with you. I do want input on the development of the Life Skills Program, even though I did not ask for input at the beginning of the decision to pursue the program. I sincerely hope that CMHC staff will give serious thought to the program. We plan to send drafts of every step we take to CMHC staff for their revision, etc. I hope CMHC staff will share the drafts with teachers, principals, students, etc.

You asked about funding for the Life Skills Program. Our Office will fully support the development of the program, printing of guides, and travel of CMHC staff to the "training of trainers" workshops. We will not be able to fund hiring additional CMHC staff to carry out the program. However, at no time do we plan to mandate that CMHC's implement the Life Skills Program.

It will be strictly by choice. We are offering it as a program resource to centers that are working or want to work with schools.

I know that many school systems in the state receive staff development as one of the services provided by CESA's. Each CESA writes a staff development plan and receives money to carry out that plan. We hope to work out arrangements with the State Department of Education whereby CESA's can write in Life Skills Training as part of their staff development plan. The CESA can then contract with the CMHC to provide training. Training for YMCA, YWCA, Girl Scouts, etc. leaders would, of course, be supported by direct fees from the participants, just as PET courses and other skill training courses are reimbursed.

I have made arrangements with   for our Office to participate in the C & A meeting in November. We will be on the program at lunch and will stay around to meet people and talk with them. Also. I'm going to show the PTA slide show during the evening film forum. Thanks for the suggestion!

Bryant, I'm not sure that this letter answers anything. I do want to say, again, that I hear you and I appreciate the fact that you care about what we're doing (or not doing).

APPENDIX D

OBJECTIVES FOR LIFE SKILLS ACTIVITY GUIDES

REVIEW SHEET FOR EVALUATION OF LIFE SKILLS ACTIVITY GUIDES

OBJECTIVES FOR LIFE SKILLS ACTIVITY GUIDES

Concept: ACCEPTANCE OF SELF AND OTHERS

Goal: To Help Young People Become More Accepting of Themselves and the Significant People with whom They Come in Contact

Objectives: To feel better about self as an individual with talents and personal qualities that are valuable

To be less critical of personal limitations

To accept personal characteristics which cannot be changed

To appreciate others' talents and accept their limitations

To be able to clarify important value issues, especially in the face of conflicting messages

To accept the decisions that others make and the values that others hold as being legitimate for them

To be able to generalize learning that occurs in specific situations to other similar situations

Concept: FEELINGS

Goal: To Help Young People be more Accepting of all Feelings

Objectives: To identify feelings

To accept all feelings as legitimate

To claim feelings rather than camouflage them

To recognize personal responsibility in choosing how to act on a feeling

Concept: BEING WITH OTHERS (Interpersonal Relationships)

Goal: To Help Young People Form More Satisfying Personal Relationships with Significant Others

Objectives: To express feelings and needs verbally to others and to feel less scared and anxious in doing so

To accept the feelings and needs of others as important to them

To negotiate productively where a conflict of needs exist

REVIEW SHEET FOR EVALUATION OF LIFE SKILLS ACTIVITY GUIDES

T. M. JIM PARHAM / Commissioner
AVID C. EVANS / Deputy Commissioner

GEORGIA DEPARTMENT OF HUMAN RESOURCES

Prevention Unit
Division of Mental Health/Mental Retardation

618 PONCE DE LEON AVENUE N.E. / ATLANTA, GEORGIA 30308

Dear Reader:

"Life Skills for Mental Health" is a program being developed by the Prevention Unit, Division of Mental Health and Mental Retardation in cooperation with the Georgia State Department of Education. I don't want to say too much about the program in the letter, because we want to see how well the enclosed material speaks for itself. It is a very rough draft of the "Leader's Guide for 12-14 year olds"--one of four activities guides that will be a part of the "Life Skills" Program. The program will also include a training session to prepare people to use the guides.

We purposefully did not send you a "finished product" because we want your input to help make this a truly good resource for teachers and other adults who work with young people and want to be an active part of helping them learn about themselves--what is important to them, where their personal "power" begins and ends in impacting their lives, and how to build satisfying relationships with other people. Many of you are the "teachers and other adults" we're talking about. Others of you work with these people in different ways--to train them, to develop policies that affect their jobs, to provide support and consultation. Whoever you are, please read this draft carefully from cover to cover. We've enclosed a brief question sheet to help you critically review this material. YOU ARE NOT LOCKED INTO THIS SHEET! If we didn't ask for the input you want to give, PLEASE attach any additional comments or scratch our review sheet completely and write your own.

Thanks for being interested and thanks for your time!

PLEASE RETURN REVIEW SHEET BY ________________ TO:

Review Sheet
Leader's Guide for
12-14 year olds

NOTE: After each question there is a space for "comments". Please indicate specific areas where improvement is needed: issues that aren't covered, parts that aren't clear, parts that are inappropriate, suggested additions. Please indicate page numbers, when possible.

INTRODUCTORY MATTER

1. How clearly does "About This Book" explain what the "Life Skills" program is, why it's important and who it's for?

    _____ Very Well _____ Acceptable _____ Needs Improvement

    COMMENTS:

2. Does "About This Book" generate any enthusiasm in you for the program?

3. How well does "Helpful Notes" provide direction for using the book?

    _____ Very Well _____ Acceptable _____ Needs Improvement

    COMMENTS:

4. As a person who might use this resource, do you have any questions that are not answered by "About This Book" or "Helpful Notes"? (Please be specific)

ACTIVITIES

5. How would you rate Part I: "Acceptance of Self and Others"? (p. 14-29)

_____ Very Good _____ Good _____ Needs Improvement

COMMENTS:

6. Did you try out any of the activities in Part I: "Acceptance of Self and Others"? (p. 14-29) What was your evaluation? (Please indicate the particular activity, page number, and evaluation for each activity you tried.)

7. How would you rate Part II: "Feelings"? (p. 30-42)

_____ Very Good _____ Good _____ Needs Improvement

COMMENTS:

8. Did you try out any of the activities in Part II: "Feelings"? (p. 30-42) What was your evaluation? (Please indicate the particular activity, page number, and evaluation for each activity you tried.)

9. How would you rate Part III: "Being With Others"? (Interpersonal relationships, p. 43-73)

_____ Very Good _____ Good _____ Needs Improvement

COMMENTS:

10. Did you try out any of the activities in Part III: "Being With Others"? (p. 43-73) What was your evaluation? (Please indicate the particular activity, page number, and evaluation for each activity you tried.)

11. What is your over-all reaction to the Guide?

	Very Good	Good	Needs Improvement
Issues Covered			
Appropriateness for Age Level			
Organization of Guide			
Appropriateness for Rural Setting			
Appropriateness for Urban Setting			
Appropriateness for Inner City Setting			

COMMENTS: (Please be specific about improvements you suggest.)

12. Do you foresee any problems (e.g., teachers' resistance, students' resistance, etc.) in implementing this program in schools? NOTE: The program will be implemented only upon request from the school.

APPENDIX E

MEMORANDA CONCERNING SELECTION OF PILOT AREAS

MEMORANDA CONCERNING SELECTION OF PILOT AREAS

T. M. JIM PARHAM / Commissioner
Georgia Department of Human Resources
Office of Prevention
618 PONCE DE LEON AVENUE N.E. / ATLANTA, GEORGIA 30308

February 3, 1977

MEMORANDUM

TO: Area Program Directors
Prevention Coordinators, Area Mental Health Programs

FROM: Xenia Wiggins, Assistant Director, Office of Prevention

RE: Participation in Pilot Life Skills for Mental Health Program.

We are getting to the point in the development of the Life Skills for Mental Health Program where we need to know which community mental health centers want to participate in the pilot phase. The training session for teams from participating CMHC's will be held in June. The activities guides will be ready (revised, printed form ready for distribution) by next fall, so that teacher in-service workshops can begin at that time.

By now, all prevention coordinators have received a copy of the strategy for the Life Skills Program and a draft copy of the first activities guide. Of course, we will be sending you draft copies of the next three guides as they are developed for input from your center's staff and from other people in your area who you feel should be involved. I hope that this memo provides sufficient additional information concerning what participation in the pilot phase involves to help your center decide whether or not to participate.

SELECTION OF CMHC's FOR THE PILOT

For the most part, CMHC's will select themselves into the pilot program by merely indicating their desire to participate. Since this is a pilot testing of the program, we want to start with a limited number of centers for the first year. If a number of centers want to participate in the pilot, the committee we've established with the State Department of Education will have to make selections. Our strategy will be to select areas where there is the most enthusiasm for the program and where centers have good rapport with a number of schools and can judge from their interactions with schools that a fair number would welcome the program. In short, we want to start in those areas where there is the greatest chance of success and the least need to "sell" the program. A good pilot will provide an opportunity for neighboring schools to see the program in action and to "sell" themselves on the idea as enthusiasm for the program spreads by word of mouth.

TRAINING TEAMS

Each center that participates in the pilot will be asked to select a team of four members to provide training workshops for teachers and other adult leaders who request the Life Skills material. The team coordinator should be a CMHC staff person, but need not necessarily be the prevention coordinator. Other team members may also be CMHC staff or they may be other community resources (school system personnel, college personnel, family mediation center staff, health educators, etc.) who have training experience in affective education skills (communication skills, values clarification, parent effectiveness training or teacher effectiveness training, or similar programs). We encourage centers to draw on community resources, particularly resources that are familiar with school system needs and have experience in teacher training. For many areas, we will be able to identify resources who have participated in special projects sponsored by the State Department of Education or federally supported training.

There is a good reason for asking each center to have a training team of four members. Each teacher training workshop can be led effectively by two trainers. By having four members on the training team, each center will have two teams capable of conducting the training workshops. The responsibility for training workshops can be divided between the two teams instead of resting solely with one team. Once teachers have participated in workshops, they may ask for follow-up assistance. There will be four people (rather than just two) available to visit teacher classrooms for follow-up. By dividing the time and responsibility for the Life Skills program between two training teams, there will be less stress on the already demanding schedules of CMHC staff.

TRAINING OF TRAINERS WORKSHOP

The Office of Prevention will sponsor a Training of Trainers Workshop to prepare CMHC teams to conduct teacher in-service workshops. There will be no cost to training teams for the TOT workshop—except the commitment of time to participate in the workshop. The TOT session is scheduled for June 8-9, 1977. (Mark your calendar!)

REIMBURSEMENT FOR TEACHER TRAINING

In some cases it will be possible for the CMHC to be reimbursed for teacher in-service training. School systems or CESA's with State-approved staff development plans can choose to add the Life Skills workshop as a training activity, and use staff development funds to pay for the Life Skills workshop through a contract between the school system and CMHC. Not all, but some State-approved staff development plans have also been approved for certificate renewal. When this is the case, teachers participating in the Life Skills workshop will earn certificate renewal credit. Certificate Renewal credit is an important incentive for teacher participation. Another option is to arrange with a local college or university for continuing education credit. The CMHC will have to negotiate these arrangements at the local level. Consultation will be available from the State Department of Education and the Office of Prevention.

IF YOUR CENTER WANTS TO PARTICIPATE

If you think your center and your area would be a good pilot area, here's what to do:

1. Send me a letter indicating the center's desire to participate by March 1, 1977. Please provide the following information:
   - Identify the CMHC staff person who will serve as coordinator for the four member training team.
   - Give a brief description of the extent to which your center has been involved with school. Especially describe those activities similar to the Life Skills Program.
   - What is your rough estimate of the number of schools in your area that would probably request the Life Skills Material?
2. The team coordinator should mark his/her calendar for June 8-9, 1977 for the TOT workshop.
3. Begin to give careful consideration to people who might serve as members of the training team.
4. Begin to talk with the school system (and CESA) in your area about the Life Skills Program. Involve principals and teachers from potential participating schools in review of the drafts of the leaders' guides as we send them out.

We will confirm centers to be included in the pilot phase by April 1, 1977. If you have any questions, please call me at (404) 894-4793. The GIST number is 222-4793.

. F. M. JIM PARHAM / Commissioner
VID C. EVANS / Deputy Commissioner

GEORGIA DEPARTMENT OF HUMAN RESOURCES

Office of Prevention
Division of Mental Health and Mental Retardation

618 PONCE DE LEON AVENUE N.E. / ATLANTA, GEORGIA 30308

March 29, 1977

Mr. George Sparks
Northwest Georgia Mental Health Center
Hutcheson Memorial Tri-County Hospital
100 Gross Crescent Street
Fort Oglethorpe, Georgia 30741

Dear Mr. Sparks,

We are pleased to confirm that the Northwest Georgia Mental Health Center will be a pilot area for the Life Skills for Mental Health Program. Thirteen area mental health programs asked to be involved in the pilot phase. Last week, I met with the Life Skills Planning Committee to select eight pilot areas. (A list is enclosed.) We feel that the areas selected represent a good cross section of the state and offer the best opportunities for a successful demonstration of the Life Skills Program.

As team coordinator, there are several steps you should take at this point. First, begin to share information about the Life Skills Program with schools in your area, particularly those schools that are likely to want the material. One good way to do this is to involve teachers and principals and other key school personnel in review of the draft guides. From here on, we will send you additional copies of the guides as we develop them so that you can distribute them in your area for input. At this end, the members of our Planning Committee from the State Department of Education will be contacting people in the school systems in the pilot areas to talk with them about the program and encourage their involvement.

Perhaps the most critical step is the selection of the remaining three members of your training team. You may choose to involve people outside the community mental health center staff as members of your team. This promotes more community ownership in the program and ties up fewer community mental health center staff in providing the in-service workshops. You should be careful, however, to insure that the people you select from the community have the freedom in their schedules and in the positions they hold to give time to the Life Skills Program. In selecting the members of your training team, we ask you to consider the following guidelines:

1. When considering people you haven't worked with before, it's a good idea to "interview" them first before you make a commitment.

2. Trainers should be comfortable with the approach and philosophy of the "Life Skills" program

3. Trainers should have experience in working with schools, particularly in the area of affective education.

4. Trainers should have some knowledge of school system needs, constraints and procedures related to in-service training.

5. Trainers should be able to anticipate concerns relating to the Life Skills Program that might be raised by teachers and school administrators. (In short, to have some understanding of what it's like to be a teacher or principal and the day-to-day issues they face.)

6. Trainers should have experience in conducting training workshops, especially workshops that actively involve participants in "learning by doing" type exercises.

7. Trainers should have experience in the following skill areas:

   a. Values clarification

   b. Communication skills (listening for feeling and behavior feedback. — These are based on the Tom Gordon Model (P.E.T.) and are described briefly in the Drafts of the "Life Skills" Leaders Guides).

   c. Role Playing

   d. Problem Solving

   e. Processing Skills (The ability to describe the learning intended in a particular training experience and how that learning applies generally to similar situations.)

   f. Group facilitation skills

All four members of the training team should plan to attend the Training of Trainers Workshop, June 8-9,1977. (I will send more information later.) Please keep some simple notes on how you go about selecting the members of your team. These will be used in the evaluation of the pilot phase.

We encourage you to involve people from the school systems in your area in planning for implementation of the "Life Skills" program. The Planning Committee members from the State Department of Education have identified the following people in your area as good resource people:

Audrey Herod, Curriculum Division, Walker County Public Schools
Francis Johnson, Curriculum Division, Chatooga Co. Public Schools
Tommie Yates, CESA
Ruth Baxley, Coordinator of Staff Development, CESA (excellent resource)

It would be a good idea to include someone from the school system as a member of your training team.

I will be in touch with you soon to see if you have any questions about the program at this point. I am looking forward to working with you in the piloting of the "Life Skills for Mental Health" Program.

Sincerely,

Xenia

Xenia Wiggins
Office of Prevention

XW/cc

Enclosure

cc: Ms. Ada Ricks
Gloria Bulloch

PILOT AREAS
LIFE SKILLS FOR MENTAL HEALTH PROGRAM

Program Area No.	Center	Team Coordinator
1	Northwest Georgia Mental Health Center	George Sparks
7	Northside Mental Health Center	Aimee Brazeman
9	Atlanta South Central Mental Health Center (Fulton County)	Ellen Yancy
14	South Dekalb Mental Health Center	Jeretha Belcher
19	Griffin Outreach Program	Bob Dixon
20	Central Georgia Comprehensive C.M.H.C. (Macon/Collaboration with Middle Georgia Council on Alcohol and Drugs)	Josie Green
28	Albany Area Mental Health Center	Karen Mauldin
33	Chatham County Mental Health Center (Savannah)	Billy Bates Howe

APPENDIX F

SCHEDULE FOR PILOT TRAINING OF TRAINERS WORKSHOP

EVALUATION SUMMARY OF PILOT TRAINING OF TRAINERS WORKSHOP

SCHEDULE FOR PILOT TRAINING OF TRAINERS FOLLOW-UP SESSION

EVALUATION SUMMARY OF PILOT TRAINING OF TRAINERS FOLLOW-UP SESSION

SCHEDULE FOR PILOT TRAINING OF TRAINERS WORKSHOP

LIFE SKILLS FOR MENTAL HEALTH

A WORKSHOP FOR
MENTAL HEALTH CENTER TRAINING TEAMS
June 7 - 9, 1977

THE SCHEDULE

Sessions will be held in Room K. Small group sessions are in Rooms E and J and the First Floor Conference Room.

TUESDAY, JUNE 7

6:00 - 6:30 p.m.	Registration, Second Floor Registration Desk
6:30 - 7:30	DINNER, Banquet Area
7:30 - 9:00	Introductory Session, Room K
9:00 -	SOCIAL, Executive Suite, Room 201

WEDNESDAY, June 8

8:00 - 9:00 a.m.	BREAKFAST, Banquet Area
9:00 - 12:15	Walk-Through of Teacher Inservice Workshop, Room K
12:15 - 1:15	LUNCH, Banquet Area
1:15 - 2:45	Walk-Through of Teacher Inservice Workshop (continued)
3:00 - 4:30	Evaluation of the Life Skills Program
5:30 - 6:30	SOCIAL, Executive Suite, Room 201
6:30 - 7:30	DINNER, Banquet Area
7:30 - 9:00	Walk-Through of Teacher Inservice Workshop (continued)
9:00 -	SOCIAL, Executive Suite, Room 201

THURSDAY, JUNE 9

8:00 - 9:00 a.m.	BREAKFAST, Banquet Area
9:00 - 12:00	A Model for Affective-Integrated Education, Room K
12:00 - 1:00	LUNCH, Banquet Area
1:00 - 1:30	Format and Guidelines for Teacher Inservice Workshops
1:30 - 3:15	Tips for Trainers
3:15 - 4:00	Wrap-up and Evaluation

LIFE SKILLS FOR MENTAL HEALTH

TRAINING OF TRAINERS WORKSHOP

June 7-8-9, 1977

TUESDAY

6:00 - 6:30 p.m.	Registration
6:30 - 7:30	DINNER
7:30 - 9:00	Introductory session 1. Introduction of staff 2. Development and purpose of Life Skills Program 3. Get acquainted activity 4. Needs assessment 5. Elicit participant concerns
9:00 -	SOCIAL

WEDNESDAY

8:00 - 9:00 a.m.	BREAKFAST
9:00 - 12:15	Walk-through of teacher inservice workshop 1. Distribute trainer handbooks 2. Listening for feeling strategy
10:30 BREAK	3. Life skills activities (small groups) 4. Behavior feedback strategy 5. Life skills activities (small groups)
12:15 - 1:15 p.m.	LUNCH
1:15 - 4:30	Walk-through of inservice workshop (cont.) 1. Values clarification strategy 2. Life skills activities (small groups)
2:45 - 3:00	BREAK
3:00 - 4:30	Evaluation of Life Skills Program
4:00 - 5:30	BREAK
5:30 - 6:30	SOCIAL
6:30 - 7:30	DINNER

7:30 - 9:00	Walk-through of inservice workshop (cont.)
	1. Role-play strategy 2. Life skills activities
9:00 -	SOCIAL

THURSDAY

8:00 - 9:00 a.m.	BREAKFAST
9:00 - 12:00	Model for affective-integrated education
	1. Presentation of the model
10:30	2. Q-Sort activity
BREAK	3. Developing lesson plans
12:00 - 1:00	LUNCH
1:00 - 1:30	Teacher inservice workshop
	1. Guidelines for participating in workshop 2. Alternative formats and content sequence
1:30 - 2:15	Tips for trainers
	Break into 5 small groups to brainstowm and discuss ideas for effective training and follow-up consultation. Reassemble in large group after break.
2:15 - 2:30	BREAK
2:30 - 3:15	Tips for trainers (cont.)
	1. Share ideas from small groups 2. Role-play situations involving consultation with teachers.
3:15 - 4:00	Wrap-up and evaluation

EVALUATION SUMMARY OF PILOT TRAINING OF TRAINERS WORKSHOP

LIFE SKILLS FOR MENTAL HEALTH

TRAINING OF TRAINERS WORKSHOP

June 7-9, 1977

Workshop Evaluation

DEMOGRAPHIC DATA

34 # Participants

33 # Evaluations

Education: See Attachment

Field:
18 Mental Health
8 Education
7 Other (includes 4 who marked mental health & education)

ATTAINMENT OF WORKSHOP OBJECTIVES

The planned objectives for this workshop are listed below. Please circle the number which indicates how well you feel each objective was attained.

	Very Successful 5	4	Somewhat Successful 3	2	Un-Successful 1
Objectives:					
1. To increase understanding of the relationship between affective and cognitive learning.	16	13	4	-	-
2. To reinforce the rationale for promoting positive affective and cognitive growth as a prevention strategy in mental health.	15	11	6	1	-
3. To create an awareness of the importance of training in Life Skills strategies and activities.	14	13	7	-	-

	Very Successful 5	4	Somewhat Successful 3	2	Un-Successful 1
Objectives:					
4. To introduce the Life Skills Program as a vehicle for positive development/prevention, and to demonstrate selected activities.	13	16	3	1	-
5. To facilitate trainers' personal knowledge and skill in Life Skills strategies.	8	20	4	1	-
6. To demonstrate various training styles.	17	9	6	-	1
7. To develop and/or increase trainers' confidence in their ability to conduct Life Skills teacher inservice training.	10	11	9	3	-
8. To provide resources for additional training, consultation and materials.	8	16	8	1	-

TEACHING TECHNIQUES

Please circle the number which indicates, in your opinion, the effectiveness of each technique. That is, how well did each technique facilitate your learning in the workshop?

	Very Effective 5	4	Somewhat Effective 3	2	In-Effective 1
1. Get-acquainted activity	12	10	6	2	1
2. Lecture	4	12	12	5	-
3. Skill practice exercises					
a) Listening for feeling	10	10	9	1	1
b) Behavior feedback	7	11	9	2	1
c) Value clarification	14	12	6	1	-
d) Role-play	26	4	1	-	-
4. Group discussion	6	22	5	-	-
5. Brainstorming	5	14	8	2	-
6. Films	17	11	3	1	-

WORKSHOP CONTENT

Please circle the number which indicates how informative you found each topic. That is, how much did you learn about each?

	Already Informed	Very Informative 5	4	Somewhat Informative 3	2	Un-Informative 1
1. Development and purpose of Life Skills Program	8	12	10	3	-	-
2. Listening for feeling strategy	14	5	9	5	-	-
3. Behavior feedback strategy	11	6	9	5	2	-
4. Value clarification strategy	7	7	14	3	1	-
5. Role-play strategy	-	4	22	4	2	-
6. Demonstration of Life Skills activities	1	12	10	9	-	-
7. Model for affective-integrated education	1	15	8	8	1	-
8. Developing affective-integrated lesson plans	-	9	14	7	3	-
9. Evaluation of Life Skills Program	1	5	8	12	4	3
10. Guidelines and format for teacher inservice	2	1	5	9	8	2
11. Tips for trainers	2	1	10	8	5	2

EVALUATING TOTAL EXPERIENCE
(See Attachment for additional comments in response to these questions)

1. How do you feel about the workshop?

(24) Very glad I came (3) Somewhat disappointed

(6) Mildly glad ____ Very disappointed

2. How well were your expectations realized?

(10) Exceeded (14) Realized (7) Somewhat Realized (2) Unrealized

3. How satisfied were you with the opportunity for participation?

(25) Very satisfied (2) Somewhat disappointed

(6) Mildly satisfied ____ Very disappointed

How would you rate the workshop leaders?

(24) Excellent (9) Good (1) Fair ____ Poor

Participants were asked to respond to the following items before and after the training workshop. Pre-workshop sample: N = 20; Post-workshop sample: N = 33.

How knowledgeable are you about the Life Skills for Mental Health Program?

Mean		Very Knowledgeable 5	4	Somewhat 3	2	Not At All 1
2.70	(Pre)	0	3	11	3	3
4.34	(Post)	15	13	4	0	0

How comfortable are you with your ability to conduct teacher inservice training in Life Skills for Mental Health?

Mean		Very Comfortable 5	4	Somewhat 3	2	Uncomfortable 1
3.25	(Pre)	4	5	5	4	2
4.41	(Post)	16	13	3	0	0

ATTACHMENT

Demographic Data: Education

Degree	#	# Working Toward Advanced Degree
B.A./B.S.	5	5
M.A.	7	2
M. Ed.	6	1
M.A.T.	1	1
M.S.W.	5	-
Master's (not specified)	1	-
Ed. S.	1	-
Ed. D.	1	-
Ph. D.	3	-
Not indicated	3	2
TOTAL	33	11

NOTE:

For the comments listed below, one(*) indicates comments by people in the field of Mental Health; two (**) indicate comments by people in the field of Education; and three (***) indicates comments by people in other fields or Mental Health/Education combined.

2. How well were your expectations realized?
   Comments:

* - Follow-up workshop needed in fall
- I expected more information re: other folks experience, data, information on how to integrate this in our present systems. What I unexpectedly gained was information re: role play and values clarification.
- I began somewhat negatively but leave positively!
- Not enough time
- I was looking for clarification of the project's concept.

** - Expected more structure around workshop format for teachers - more concrete plans.
- I would have liked to have the trainer's manual Tuesday evening so I could have used my own time to gain a conceptual framework. Then the activities could have demonstrated the organization, experiences, techniques. Since I must leave at 2:30 I didn't get closure which I realize is somewhat due to my own priorities.

*** - Role playing was extremely good. Others were repetitive for me. Facilitations were all excellent. Also real good was relating skills to classes/courses.
- I feel that the Life Skills workshop was well planned and implemented.
- Introduced to a number of interesting/usuable strategies even-beyond use in the Life Skills pilot - i.e., personal growth for me!
- More organized than expected.

ATTACHMENTS:

3. How satisfied were you with the opportunity for participation?
Comments:

* - There was every opportunity for full participation.
- The leaders fully extended themselves to make this possible.
- Group too large for enough participation.
- Found I was familiar with most of the material and the disorganization of trainers annoyed, frustrated and confused me.
- Too many people in too big a room.

** - Was made to feel comfortable
- Because of time, we were sometimes cut-off in our discussions which I think were relevant for us as trainers.

*** - Said above - excellent leaders
- It was good to have a chance to participate.

4. What was your major reason for coming to the workshop.

* - To learn how to present the concept to school personnel - both administrative and teaching.
- To become a trainer and to acquire additional skills.
- To learn new skills and add ways to train others in skills I already train others.
- Necessary to provide the training to the teachers.
- More work and Life Skills activities
- Learn effective sequencing of Life Skill training.
- Gain knowledge about Life Skills training - expected higher level material.
- Interest and to learn new skills.
- I had to.
- Learn training in Life Skills.
- To integrate the total experience - lots of individual letters etc. in past - now pulled together.
- To learn more about the expectations of the trainers in the Life Skills Program.
- Asked to participate by clinical director.
- Interest in doing Life Skills training.
- To assist team leader in setting up a Life Skills Program.
- Directed by the MHC Coordinator.
- Learn what this was all about.
- To learn, to meet, to corroborate.

** - To learn more about teacher training outline - How and when pilot components were to be done.
- To gain more knowledge in putting Life Skills to work in my class.
- To gain knowledge and learn skills for relating better.
- Personal knowledge - implementation of program in schools.
- To become a teacher for teachers for Life Skills.
- To find about listening and role playing.
- To involve myself in another project to facilitate education and mental health cooperation.

ATTACHMENTS:

*** - Reaffirm training skills - "accreditation"
- To learn the skills necessary for understanding and teaching Life Skills.
- To increase knowledge and training skills; to present workshops (Life Skills) effectively.
- To be able to help others develop a life skills program, in my area.
- To learn and explore the concepts we ended up doing.
- About life skills: To perhaps find an alternative for doing another kind of things. Maybe a way out of present responsibilities.
- Become informed about Life Skills Program.

5. a. What one aspect of the workshop was most helpful to you?

* - The model for affective-integrated education and development of lesson plans.
- Model affective-integrated education.
- Role play demonstrations and film.
- Role play information, I find applicable to a wide variety of situations for myself.
- Practice with activities.
- Group discussions which lead to awareness of perspectives of other teams, their backgrounds, ideas, skills, suggestions.
- Role playing, Socio Drama.
- Model for affective-integrated. (Application of skills learned.)
- Cognitive Affective Education Model.
- Role playing, etc.
- Whole concept of prevention or development of adequately functioning students.
- The openness of instructors were all helpful in facilitation also.
- Role playing.
- Role playing.
- Role playing.
- Behavior feedback.
- Role playing.

** - Role-play sessions were informative and filled a void in my background.
- Role playing.
- Behavior feedback.
- Role playing.
- Possibility of role playing as a tool.
- The people I met.
- Role playing demonstration.
- Integration into teachers' subjects becaust I must keep reminding myself that we must deal with "normal" kids.

*** - Role playing as a strategy.
- The model of affective-integrated education.
- Listening for feelings.
- Listening and feeling strategy.
- Sociodrama - Pantomine.
- Values clarification.
- Role playing.

ATTACHMENTS:

5. b. What one aspect was least helpful?

*
- Get acquainted activities.
- The lectures on behavior feedback and active listening.
- Lectures.
- Material too basic, therefore boring at times. Too many hrs. of intense training.
- The amount of liquor I consumed!
- Role playing on listening for feeling (e.g. - mother and daughter.)
- Bladder distension
- Can't really say - All served a purpose . . . have reconsidered - The last afternoon was disorganized - some of time could have been spent to finish other sessions.
- The role play at the beginning of the sessions although it had many positive aspects.
- Behavior feedback.
- Behavior feedback.
- Behavior feedback was not covered enough in the interest of time.
- Behavior feedback - because I haven't used this for so long.
- Role play.
- Evaluation, explanation of . . .

**
- Information on teacher training organization.
- Cannot rate this.
- Listening for feeling.
- Affective integrated lesson plans.
- We have done a lot of value clarification.
- Values clarification
- Tips for trainers (last afternoon session)
- Strategy on Behavioral Feedback.

***
- Problem over-emphasized affective education as "cure all". Need to realize for some cognitive is extremely useful. Check-out Cairo, Illinois school system (Newsweek magazine)
- Development and purpose of life skills program.
- All of the caffeine in the coffee and cokes.
- Evaluation
- Lectures

6. How would you rate the workshop leaders?
Comments:

*
- They are obviously enthusiastic about life skills for mental health and this comes across genuinely.
- They were supportive of each other and positive - very enjoyable team.
- Prepared, organized, competent, skilled, responsive
- Joan in particular was talented in her area.
- Comfortable, warm, knowledgeable, active

ATTACHMENTS:

** - All were exceptional and were chosen with care.

*** - Worked very well as a team - and you all listened to us and responded in helpful ways.
- Socio-Drama and Values Clarification - most outstanding.
- Each especially affective in their field. Real treat to work with such pros.

7. What comments do you have about the general structure of the workshop? (Consider: facilities, number of people, length, amount of material covered, etc.)

* - Evening working sessions are unusual but they effectively utilized what is most often dead time.
- Excellent facilities.
- The facilities were excellent - time to spend with others getting to know them was helpful, too many people - got a little long.
- Facilities excellent; people - probably 10 too many, but ok; length - just fine; material covered - ok.
- Fine
- Too many people; good blend of different activities and styles.
- Diverse educational levels and backgrounds made it difficult to be "middle of the road" and at times left me bored and resentful although material was well-presented.
- Everything was great - not enough time for content/experiential.
- # of people too large for enough participation needed more time for certain activities; facilities were fine.
- Good
- Trainers conscious of not enough time to cover their area - their verbalization made me feel short-changed - should have taken time for completion.
- Especially good facilities and well planned in all aspects.
- Working sessions were too long. Not enough breaks.
- OK
- The structure could have been improved by adding another day.
- Too many people in the workshop. Workshop did not move quickly enough. Material covered superficially as was necessary.
- Too many folks; too short; room too big.
- Feel that effectiveness for me (personally) could have been increased with manual in hand near the beginning.

** - A lot of material to cover - a lot that didn't get covered. Could have run 3 days. Organization appeared to be 0.
- Not enough time.
- Facilities, consultants, food, organization - all great
- Great - Perhaps a comment on the courtesy of being on time would have helped so many people being late to workshops.
- Too much lecture that was repetitive turned me off. I also wanted more practical integrated with theoretical than I got.
- Facilities -good; The group was too large.
- In a 12-hour day I become satiated long before the "meaty" stuff is over. 3-day scheduling would have been better for me.

ATTACHMENTS:

*** - Everything was excellent. Only shortcoming was packing a lot into limited time. Could use more time for R and R.
- More natural setting desirable, less closed in; too many people; too long.
- Less people might have made it easy for me to volunteer to role play and respond verbally.
- Very helpful.
- Very fine.
- Facilities good, people, number very good; Length good but heavy.
- Tired of same place but very adequate facilities. Great idea to have social hour so people could gleen information from each other.

8. List ways the workshop could have been improved to have made it a richer learning experience for you, or to have better prepared you to conduct teacher inservice training in Life Skills.

* - More feedback on the test run with teachers.
- To have training guides available.
- Would have been helpful to actually try teaching an area in our groups.
- More integration in the beginning between experiential and didactic.
- It would have been helpful to have the trainers manual earlier.
- Presentation of strategies and activities seemed too disjointed; they didn't come together; teachers will get just a token exposure to methods they need concentrated practice/feedback in.
- Higher level material would have been more interesting - more sophisticated techniques could have been covered.
- Lengthen time for learning each skill.
- Possibly grouping in smaller groups for some areas by level of expertise.
- Enough time to finish each session adequately.
- Probably to have given me and others a little time in the beginning to say where we were when we arrived.
- More participation in structuring activities that might be used with kids.
- More experiential.
- More small group activities. Increased knowledge. Better organization by trainers.
- More smaller groups.

** - Model teacher training workshop. That may have been planned but it didn't come off. It wasn't structured enough. We can always adapt or deviate from a model.
- More time for more "building blocks."
- A session on facilitative responses which would emphasize empathy for persons and their feelings.
- Perhaps if you do not already know the reluctance of administrators, Board of Education, to accept anything new you could appreciate our concerns vis a vis these super conservatives.
- I never felt the listening, behavior feedback, and values clarfication was as practical, intense, and also theoretically rounded out as was the role playing.
- More structured participation in small groups.
- 1-manuals in hands first; 2-simulation type activities, yes; but more toward workshop for trainers.

ATTACHMENTS:

*** - Extend over longer period - more informal time for whatever.
- Smaller groups; more involvement and discussions; opportunities to practice the exercises.
- More time for leaders to have lectured more.
- Longer - some more practice with facilitating some of the skills.
- Having manual to read first or having read some of Life Skills materials in advance - I've very little background.
- More modeling of teacher training sessions.

9. What other topics or issues would you like to see covered in a follow-up workshop?

* - How teachers actually utilized the Life Skills Program; How teachers actually accepted the Life Skills Program; and How they react to the Guides.
- Shared experiences of implementing and carrying out Life Skills inservice.
- A systematic way of dealing with our problems, successes, and needs.
- Consultation help.
- Add the other communication skills to reflective feeling.
- More time for Socio-drama's building blocks and specialized techniques involved.
- More role playing but in areas related to teachers and what they'll be using it for.
- Follow up teaching and what others have done.
- To hear from team committees as a unit.
- Role playing again because it's the most fun activity and I think fun is the key element in this programs's success.
- More role playing material.
- Feedback from others in this group; more relevant data.

** - Relating activities to content areas.
- I would like some extensive theoretical work on values clarification with illustrative examples.
- Specifics on how to work with team members.
- Evaluation; Conferences with task groups as opposed to large session.

*** - Review what has occured - successes and failures.
- Practice.
- The usage of Life Skills in residential and other community agencies.
- More foundations for Role Play on how to teach teachers
- Feedback on different activities.

10. General Comments:

* - Good and Productive Workshop
- Good workshop
- Enjoyed it.
- Leaders were generally excellent and the format was well designed.
- The Life Skills attempt is ambitious; I really am glad to see the scope and enthusiasm of the project; it has the potential for a major position impact. Training of teachers needs to be longer and more thorough.

ATTACHMENTS:

- Trainers did very well considering they were expected to reach such a variety of educational levels, backgrounds and interest. Selection of participants was more responsible for the negative parts of my evaluation, rather than the fault of the trainers.
- The workshop leaders were extremely good - The informality of the overall session was conducive to people getting to know each other.
- Enthusiasm for project steadily seemed to be built up during the 2 days.
- You all did an especially good job of affective integration - with the total content. Thank you all.
- This has been a good workshop but I was so exhausted at points that I couldn't be involved in the session even though I wanted to.

** - We need definite guidelines, deadlines, completion dates, receipt of manual dates, etc. I can only say "sometime this fall" for so long.
- Don't under estimate the teachers. They can handle it.
- Any endorsement from the office of Education would help administrators decide about Life Skills.
- Focus. Focus. Focus.
- A good experience.

*** - I enjoyed the people who led the workshop. All were really nice people and very sincere.
- Everything presented was helpful and meaningful, but I have found myself very sleepy and bored. The suggestions under number eight should help.
- The workshop was a big success for me and my feelings. Thanks.
- Thanks.
- Very good conference - Liked the acceptance of ideas from the group and the non-threatening environment.
- Would have liked to have gone through more activities like ones that will be in guide.

SCHEDULE FOR PILOT TRAINING OF TRAINERS FOLLOW-UP SESSION

LIFE SKILLS FOR MENTAL HEALTH

Follow-up Workshop For Trainers
October 25-27, 1977

Schedule

All sessions will be held in ROOM K (Second Floor)

TUESDAY, OCTOBER 25

6:00 - 6:30 p.m.	Registration	Second Floor Registration Desk
6:30 - 7:30	Dinner,	Banquet Area
7:30 - 8:30	Introductory Session Slide Presentation	
9:00	Social	Executive Suite (Room 201)

WEDNESDAY, OCTOBER 26

8:00 - 9:00 a.m.	Breakfast	Banquet Area
9:00 - 10:30	Staff Development Plan	
10:30	Break	
11:00 - 12:30 p.m.	Evaluation Issues	
12:30 - 1:30	Lunch	Banquet Area
1:30 - 4:30	Problem Solving Session (Breaks will be provided)	
5:00 - 8:00	Cash Bar Happy Hour/Dinner CHARLIE WILLIAMS	
9:00	Social	Executive Suite

THURSDAY, OCTOBER 27

8:00 - 9:00 a.m.	Breakfast	Banquet Area
9:00 - 10:30	Affective Integrated Model (follow-up training)	
10:30	Break	
11:00 - 12:30 p.m.	Communication Strategies (follow-up training)	
12:30 - 1:30	Lunch	Banquet Area
1:30 - 3:15	Role Play	
3:15 - 3:30	Wrap-up and Evaluation	

EVALUATION SUMMARY OF PILOT TRAINING OF TRAINERS FOLLOW-UP SESSION

LIFE SKILLS FOR MENTAL HEALTH

FOLLOW-UP WORKSHOP FOR TRAINERS

October 25-27, 1977

WORKSHOP EVALUATION: SUMMARY

Age: ______ under 25 __11__ 25-34 __3__ 35-45 __4__ over 45

Field: __12__ Mental Health __2__ Education __4__ Other (Specify) ____________

1. The purpose of this workshop was to a) provide information, b) assist with problem-solving, and c) provide additional training in the Life Skills strategies. With these objectives in mind, please circle the number below which indicates how informative or helpful you found each section of the workshop.

	Very Much		Somewhat		Very Little
a. Slide presentation	5 (3)	4 (7)	3(2)	2(4)	1(1)
b. Certificate Renewal Program	5 (4)	4 (2)	3(7)	2(1)	1(3)
c. Research & Evaluation	5 (2)	4 (4)	3(8)	2(2)	1(1)
d. Problem-solving Session	5 (6)	4 (8)	3(1)	2(3)	1
e. Affective-Integrated Model	5 (15)	4 (2)	3(1)	2	1
f. Communication Strategies	5 (3)	4 (5)	3(3)	2(2)	1(1)
g. Role-Play Strategy	5 (9½)	4 (3½)	3	2	1

2. How do you feel about the workshop?

__(13)__ Very glad I came
__(1)__ Mildly glad
__(3)__ Somewhat disappointed
__(1)__ Very disappointed

Comments:

See attachment.

3. How well did the workshop meet your expectations?

__(5)__ Exceeded __(6)__ Realized __(4)__ Somewhat realized __(1)__ Unrealized

Comments:

See attachment.

Workshop Evaluation

4. How satisfied were you for the opportunity for participation?

(13) Very satisfied　　(1) Somewhat disappointed
(4) Mildly satisfied　　(1) Very disappointed

Comments:

See attachment.

5. What did you find most helpful?

See attachment.

6. What, if anything, did you find least helpful?

See attachment.

7. How would you rate the workshop leaders?

(12) Excellent　(4) Good　(2) Fair　(1) Poor

Comments:

See attachment.

8. List ways the workshop could have been improved to have made it a richer learning experience for you, or to have better prepared you as a Life Skills Trainer.

See attachment.

9. Would you be interested in additional workshops? (14) Yes (4) No

If yes, what topics or issues would you like to see addressed?

See attachment.

10. General Comments or Suggestions:

See attachment.

ATTACHMENTS:

2. How do you feel about the workshop?

Comments:

- Good ideas (and plentiful) about how to conduct the workshop with teachers, Good contact with people, lots of positive strokes given and received; Stimulation and affirmation of present activities.
- I am still confused about staff development plan and slide presentation was difficult understanding. Too much playing around (participants jokes and outbursts) with each other - waste precious time
- Sometimes felt talked down to
- I had a lot of difficulty hearing the slide presentation
- Good pace and spacing!
- The workshop was beautiful and so were the people
- Felt material was redundant and poorly presented - some of material - Judy did a beautiful job to involve the group. For the most part, it was very boring.
- Affective - Integrated model made it worthwhile - the rest was repetitive, especially the communication strategies with which I have some doubts.
- It made me feel more comfortable about doing these workshops.
- Great getting together with group and sharing experiences.
- (1) Peggy was very poor in her own utilization of listening for feeling. PLUS she came across to me a phony. (2) Behavior Feedback and L.FF. were presented at levels that didn't take into consideration that we had already been trained and had 4 months to research it.

3. How well did the workshop meet your expectations?

Comments:

- I also learned a lot of particulars (e.g., Kline's existance) to facilitate workshop success and ensuring evaluation.
- What expectations?
- I am much more confident for future workshops of my own.
- Hard to say - I had essentially negative expectations - have had essentially positive experience.
- Expected more group involvement and mutual sharing of experiences of other workshops.
- I came expecting nothing valuable and got hints that will help me help teachers make the activities really work.
- Affective integrated ed. and problem solving addressed my needs, but unfortunately they covered only a small % of the time of the workshop and the more negative experiences i.e. L.FF. & Peggy's other areas of participation.

4. How satisfied were you for the opportunity for participation?

Comments:

- Too much total group
- Primarily a review of didactic material
- Leaders provided and insured much opportunity - that was well taken & used
- Again depends on the areas

5. What did you find most helpful?

- The presentation of Affective Integrated Model helped cognitive understanding and the structure was a fine example of the way a workshop can be presented.
- Curriculum design - role playing information
- Affective education integration needed
- Listening for feeling
- Reviewing life skills activities to better help group understand and use materials with others (teachers, social workers, etc.)
- Affective integration, role play
- Refinement of affective integration skill and knowledge
- Some of the techniques for brainstorming , etc.
- Judy's session on Thursday A.M.
- Affective-Integrated Model
- Problem Solving
- Understanding Certified Renewal Process
- Others sharing their workshop experiences with me
- Affective-Integrated Model Update
- Problem solving
- The shop talk and problem solving opportunities built into the workshop. Plus review of 4 strategies.
- Affective integration, Role playing
- Affective integration education and role playing

6. What, if anything, did you find least helpful?

- Good information yet poor attitude in C.R.P.
- The communication strategies were repetitive - not very well led
- Most of the 1st day
- Nothing - everything good
- Certificate part - confused
- Problem solving and communication
- The slide presentation
- Peggy's presentation part with problem solving - although overall problem solving session was okay; she seemed to be misreading the problems presented.
- C.R.P.
- Behavior feedback rehash
- Certification renewal
- Listening for feeling

7. How would you rate the workshop leaders?

Comments:

- A good good overall.
- Most were excellent; 1 was bad
- Some excellent; some fair
- Judy, John and Joan added new information and reached a higher level of involvement for me
- I don't think anyone dealt with participant ambivalence. This may have been good or bad, I'm not sure.
- Poor preparation and planning - Moved very slowly with few group activities built in; Judy & Joan did fantastic jobs.
- Judy, John & Joan - excellent professional, knew their stuff
  Bob - low key, good, not as much clarity and dynamism as the others
  Peggy - fair, seemed insecure and inexperienced as a leader.

8. List ways the workshop could have been improved to have made it a richer learning experience for you, or to have better prepared you as a Life Skills Trainer.

   - We keep saying how good it feels for the kids. I would like for us to have more experience from their viewpoint. Lead us through the exercises so we can feel it from their side. We did some on this - I'd like to do more.
   - More doing in workshop settings.
   - Group leadership skills should have been covered more.
   - Hope the audio on the slide presentation can be improved. It was beautiful.
   - Less joking and playing around.
   - More activity - less lecture - some of the lecture could have been gotten across in more exciting ways if more activity was applied (as Judy did).
   - More utilization of resource person from NC on "Mechanics", from initial request for LS Workshop to implementation.
   - Needs to move more quickly through the material and emphasis on activities.
   - I seriously doubt the value of Active Listening (for feelings, etc.) and Behavior Feedback (that is TET) for everyday use in the classroom.
   - Provide opportunity to practice conducting sessions.
   - None
   - Discuss specific detailed of workshops that people have done.
   - More sharing of experiences and problem solving, more advanced level of training.

9. Would you be interested in additional workshops? If yes, what topics or issues would you like to see addressed?

   - Continue on problem solving issues; train us further in specific areas where we need more assistance.
   - Sharing with other teams on things that work or don't even having various teams do parts. More training on specific strategies may be redundant.
   - Team developing, group leadership skills
   - Value clarification
   - Life skills used with parents.
   - Small group sessions
   - More building blocks for Role-Play strategy. Continued feedback on research and evaluation; and continued experience with affective intergration.
   - Perhaps listening to some of the authors of the best books.
   - Classroom consultation skills
   - School-teacher consultation e.g. follow-up on Life Skills
   - Team building
   - I feel comfortable with my abilities in this area now.
   - Unless the format was more activities oriented and sharing during workshop among members.
   - Strategies for hooking teachers, principals
   - Team workshops
   - What should be covered in follow-up sessions and teacher observations.

10. General Comments or Suggestions:

- I would like our training to continue during these 3 pilot years. If more teams need to be trained, perhaps we could help train them I value the assistance and support of our professional consultants, I want this to continue.
- Glad to be here; productive
- Very well organized. Opportunity to go to Williams Pinecrest Lodge was neat.
- I was unsure about coming because didn't know if additional materials would be presented, but am happy with outcome.
- The food and accommodations remain excellent. Also general concern remains high and caring for the success of the workshop.
- Re do the sound on the slide presentation.
- Beneficial workshop.
- I think it is extremely unfortunate that sound quality on tape/slide show is so poor - I think this will be quite detrimental.
- None - satisfied mind for once.
- The sound track on slide presentation was barely audible in spots and makes total effectiveness limited. I don't plan to use it unless we use only the slides and the format of the script.

11 25-34

- 9 Mental Health
- 1 Education
- 1 Other (Private agency in Drug Prevention)

3 35-45

- 2 Mental Health
- 1 Education
- 0 Other

4 over 45

- 1 Mental Health
- 0 Education
- 3 Other (1 Primary Prevention, 2 did not identify)

Totals:
- 12 Mental Health
- 2 Education
- 4 Other

APPENDIX G

PLAN FOR SDU CERTIFICATION RENEWAL

PLAN FOR SDU CERTIFICATION RENEWAL

APPLICATION FOR
A PLAN FOR SDU CERTIFICATION RENEWAL

Submitted by

Prevention Unit
Division of Mental Health and Mental Retardation
Georgia Department of Human Resources

The Attached application is hereby submitted to the State Department of Education of the State of Georgia by the Division of Mental Health and Mental Retardation, Georgia Department of Human Resources

by William A. Allerton, M.D. Date 9/13/77
Director

Division of Mental Health and Mental Retardation, Georgia Department of Human Resources

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Department of Human Resources, (DHR) Division of Mental Health and Mental Retardation, Agency Application for Certificate Renewal

Standard I. Goals, Policies, and Procedures

A. Goals:

The goals for the DHR-Division of Mental Health and Mental Retardation Agency Application for Certificate Renewal were determined through an examination of Goals for Education in Georgia, and the goals for education of the State Board of Education. Based on this examination, the following is a list of goals based on student need toward which certification renewal will be directed.

1. Students possess the skills needed to make informed decisions as consumers, citizens, and workers.

2. Students have a philosophy based on a good self-image which will enable them to meet challenges in a constructive way while maintaing personal integrity and accepting and appreciating individual differences.

3. Students have an understanding of the concept that life styles in a changing technological society are directly affected by those technological changes, and that education is an on-going process which will enable them to acquire or expand life skills needed to successfully participate in that society.

4. Students possess an understanding of and respect for themselves--their abilities, interests, values aspirations and limitations--and use this understanding to set personal goals.

B. Policies and Procedures

The DHR Division of Mental Health and Mental Retardation agency will submit to the person responsible for staff development in each local school system (from which educational personnel request to paraticipate in a staff development activity under this agency application) a list of goals for this certification renewal plan. The local system staff development coordinator or superintendent will examine the goals to determine if they are consistent with the system's goals and improvement objectives and will verify the appropriateness of these goals by completing the DHR-Division of Mental Health and Mental Retardation LEA Approval Form, DHR-1 (appendix A)

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Standard II. Educational Personnel Needs Assessment

Based on the goals stated in Standard I above, the DHR Division of Mental Health and Mental Retardation will develop SDU training programs that will individually be submitted to the state Department of Education for approval and upon their approval are incorporated as a part of this agency application. This information will be communicated to selected LEA's in the State who are located in a community mental health center (CMHC) service area which can provide the specific training activity. The participating LEA's are responsible for the external and self assessment determination of the educational needs of their professional personnel. They are so certifying to this assessment and need by completing "The Application for Staff Development Unit Approval," DHR-2 (Appendix A).

Standard III. LEA Approval of Staff Development Plans for Educational Personnel

A. Certification Renewal Programs

The certification renewal programs developed by the DHR-Divisions of Mental Health and Mental Retardation are comprehensive in scope and specific to the needs of educational personnel employed by local school systems. Each individual training program has been developed as a self-contained program to its self and includes as a minimum the following elements:

1. the goals for the participant;
2. the improvement practices to be implemented;
3. the specific objectives to be met and activities to be conducted;
4. the specific competencies to be demonstrated with the associated performance indicators identified;
5. the identification of the staff responsible, the length of the training program, the instructional strategies and experiences. (The location of each training program will be determined by the situational need and contained in the publication notification to the LEA's.)
6. the participant's plan for implementation which includes specific details and must be designed to meet established criteria;
7. the on-the-job assessment procedures designed in accordance with the participant's plan for implementation, as stated on the assessment plan (DHR-3, Appendix A).

The training programs for certification renewal to be offered by the DHR-Division of Mental Health and Mental Retardation are contained in detail with all the elements cited above in Attachment I. Each training program (upon approval by the State Department of Education) is incorporated in Attachment I.

B. Approval Procedure

Each individual desiring to receive SDU credit must file a certified Application For Staff Development Unit Approval Form DHR-2, Appendix A, with the DHR-Division of Mental Health and Mental Retardation prior to participation in the specific training program.

Standard IV. Completion of Preparation

In order to successfully complete the preparation phase of the certification renewal training activities, individual participants must meet the following four requirements:

1. Attend a minimum of 10 clock hours of instruction for each SDU unit as verified by attendance records maintained by the instructor; and

2. Demonstrate a predetermined level of competency based on each rating scale established for each certification renewal activity; and

3. In a training activity involving contact hours with an instructor, no more than 10% of the total contact hours will be allowed as excused absences. The term excused absences as used here is defined as those absences approved by the instructor. It will be the responsibility of the participant to make up all excused absences with the instructor at the convenience of the instructor. One or two make-up sessions will be scheduled as necessary at the conclusion of each certification renewal program for those participants who have excused absences. All requirements for the completion of the preparation phase of a program must be met within six weeks of the final date of the regularly scheduled program of instruction.

4. Develop an individual plan for implementation including an outline of procedures that meet established criteria.

Standard V. On - the - Job Assessment

A. Selection of Evaluators

A team of a minimum of two evaluators will conduct an on-the-job assessment of each aprticipant following the preparation phase of the certification renewal training activity. Represented on each team of evaluators will be a specialist in the content area of the program, a local school system professional who is familiar with the activity, or other trained professional from the LEA, or DHR-Division of Mental Health and Mental Retardation staff. Additional evaluators could include a staff development coordinator, curriculum director, principal, content specialist, or a professional peer.

B. Training of Evaluators

A selected group of CMHC training staff will participate in a workshop in order that they may serve as competent evaluators in the assessment of training activities approved for SDU credit. Workshop participants will be trained in the utilization of the Purdue instrument, observation techniques, and assessment procedures in order to assure the interreliability of the evaluators judgments.

From this group of trained professionals, a team will be selected to perform the on-the-job assessment for a particular SDU credit training activity. Based on the type of assessment to be conducted, additional qualified personnel may be identified to serve on the team.

C. Procedure for On-the-Job Assessment

Each participant in a staff development unit credit program will meet with the evaluation team and schedule a time for conducting the required on-the-job assessment. During this meeting, the discussion will include the procedures for assessment, instruments to be used, and expectations of the evaluation team in terms of established criteria based on the approved implementation plan developed by the participant prior to completion of the preparation phase of the training activity. Procedures, instruments, etc., will be defined in detail in the individual assessment plan (Form DHR-3, Appendix A) and co-signed by both the team members and participant. The on-the-job assessment phase of the training activity must be completed within six months of the final date of the scheduled preparation phase. The evaluation team will furnish a written report of the on-the-job assessment to the instructor of the program who will forward a copy of this report to the participant.

Standard VI. Recommendation of Certification Renewal

Recommendation for certification renewal credit will be made upon the satisfactory completion of each of the following:

1. verification by the instructor that the required number of contact hours has been completed by the individual;
2. verification by the instructor that the individual has demonstrated at a pre-determined level all competencies listed in the preparation phase of the

training activity; and
3. verification by the program evaluation team that the individual has successfully implemented the approved plan.

The Individual Recommendation of Certification Renewal (Form DHR-5, Appendix A) will be completed for each participant at the conclusion of the program. This document will become a part of DHR-Division of Mental Health and Mental Retardation records and a copy will be forwarded to the appropriate local school system superintendent or his designate.

The DHR-Division of Mental Health and Mental Retardation will comply with the policies and administrative procedures established by the Georgia Department of Education for recommending individuals to the Teacher Certification Department for certification renewal credit.

Standard VII. Program Coordinator

Xenia Wiggins will coordinate the DHR-Division of Mental Health and Mental Retardation certification renewal program. She is currently the Assistant Director of the Prevention Unit of the Division of Mental Health and Mental Retardation. She has worked extensively in developing, coordinating and implementing mental health education programs. She will delegate responsibilities for coordination of various components of the certification renewal program to appropriate DHR staff members. A resume for the Coordinator appears in Appendix B.

In an effort to effectively coordinate staff development activities across local systems within the CMHC service areas, the DHR-Division of Mental Health and Mental Retardation coordinator for the staff development certification renewal program will meet with local CMHC training coordinators and other training team members for the purpose of jointly planning and evaluating staff development activities. One purpose of these meetings will be to coordinate resources and limit duplication of effort.

Standard VIII. Record Keeping

Records will be maintained to document and verify the recommendation to the Georgia Department of Education for certification renewal. The purpose of each form utilized for record keeping has been outlined in the appropriate section. All forms to be used appear in Appendix A.

Standard IX. Appeals Channels

A participant desiring to appeal the recommendation of the DHR-Division of Mental Health and Mental Retardation certification renewal coordinator has the option to appeal the recommendation through the following established appeals process:

1. Within one week of the final recommendation for certification renewal the participant must notify the instructor in writing of his desire to appeal the recommendation. The instructor and participant will schedule a time to discuss the appeal. The instructor will notify the participant of judgment made concerning the appeal within five days of the discussion.

2. If the matter is not resolved through the process cited in item one, the participant must submit written notification within five days of his desire to appeal to the DHR-Division of Mental Health and Mental Retardation certification renewal program coordinator. The program coordinator will schedule a meeting with the participant, the instructor, and the authorizing on-the-job assessment evaluator to discuss the appeal. The DHR-Division of Mental Health and Mental Retardation program coordinator will notify the participant within five days of the judgment.

FORM DHR-1

DHR - Division of Mental Health and Mental Retardation
LEA Approval Form

LEA Name______________________________

Address______________________________

The following are a list of goals from the DHR-Divsion of Mental Health and Mental Retardation Certification Renewal Plan:

1. Students possess the skills needed to make informed decisions as consumers, citizens, and workers.
2. Students have a philosophy based on a good self-image which will enable them to meet challenges in a constructive way while maintaining personal integrity and accepting and appreciating individual differences.
3. Students have an understanding of the concept that life styles in a changing technological society are directly affected by those technological changes, and that education is an on-going process which will enable them to acquire or expand life skills needed to successfully participate in that society.
4. Students possess an understanding of and respect for himself—his abilities interests, values, aspirations and limitations—and uses this understanding to set personal goals.

I have examined the above goals and have determined that these goals (are consistent, are not consistent) with the goals, improvement objectives and staff development policies of this school system.

DATE____________________

NAME__________________________

POSITION______________________________

Note: This form must be signed by the LEA superintendent, his designee, or the staff development coordinator.

APPLICATION FOR STAFF DEVELOPMENT UNIT APPROVAL

Name ____
Last First Middle

School ____________________ Certificate Number ____________

Social Secutiry Number ____________ Date of Birth ____________

School System ____________________ Position ____________

Highest Degree Obtained ______________________________

Applicant has attended workshops in the following areas: (Check all that apply)

___ values clarification
___ Creative Drama/Role Play
___ Conflict Resolution
_____ Communication Skills
_____ Teacher Effectiveness Training

Home Address ______________________________

Home Phone Number ____________________

SDU Number __________ Hours Credit __________ Contact Hours _____

SDU Title ____________________ Beginning Date ____________

SDU Instructor ____________________ Agency ____________

Training will be conducted as
__________ individual
__________ group activity

SDU Credit will be applied to
__________ certification renewal
__________ local system requirements
__________ other (specify)

Participant's Training Activity Objectives for this SDU:

I hereby certify this person for participation in the above named SDU Credit Program.

____________________ ____________________
Superintendent or Designee System

____________________ ____________________
Position Date of Approval

Fill out in duplicate.

Remarks or special interests on back

FORM DHR - 3

INDIVIDUAL ASSESSMENT PLAN FOR STAFF DEVELOPMENT UNIT CREDIT

NAME ____
Last First Middle

School ____________________ Position ____________________

SDU Number ______________ Unit Hours ____________ Contact Hours ____________

Certificate Number ______________ Social Security Number ______________

Date for Assessment Visitation ____________ Time ____________ to ____________

Procedure for implementation (from individual's plan for implementation).

Assessment methods for determining if the participant's plan is successfully implemented: (List any instruments used.)

Participant ______________________________

Date ______________________________

Evaluating Team

____

____

____

____

FORM DHR-4

REPORT FOR ON-THE-JOB ASSESSMENT

Name ____
Last First Middle

School ____________________ System ____________________

SDU Number ____________________ SDU Title ____________________

Certification Number ____________________ Social Security Number ____________________

Check the option below that indicates the evaluating team's assessment of the individual plan of the participant:

1. ________ satisfactorily implemented 2. ________ not implemented 3. ______ recommend a second on-the-job assessment

NOTE: If either options 2 or 3 are checked, list specific reasons or citations for such assessment in the space below.

Date ____________________ Evaluation

____

____

____

____

____

FORM DHR-5

INDIVIDUAL RECOMMENDATION FOR CERTIFICATION RENEWAL

NAME ____
Last First Middle

Date of Birth ______________________

Teacher Certification Number ______________ S.S. Number ______________

School System ____

SDU Number ______________ SDU Credit Hours ______________

SDU Title ____

SDU Beginning Date ______________ Ending Date ______________

	SATISFACTORY	UNSATISFACTORY*	AUTHORIZED SIGNATURE
Contact Hours Met			
Preparation Phase Completed			
On-The-Job Assessment			

*If checked unsatisfactory, please explain in the comments section.

Recommended for Certification Renewal YES NO

DHR-Division of Mental Health and Mental Retardation
Certification Renewal Program Coordinator ______________________

Date ______________________

COMMENTS:

Fill Out In Triplicate: DHR copy, School System copy, Individual copy

ATTACHMENT I
revised 6/78

SDU 1 LIFE SKILLS FOR MENTAL HEALTH

Description: An experiential study of selected fundamental skills in oral communication, role playing, and clarifying values to help students explore issues related to self concept, feelings and interpersonal relationships. The program is designed for teachers of grades K - 12.

Hours Credit: 2 State Staff Development Units (SDU) 20 hours

Goals Being Addressed:

1. Students possess the skills needed to make informed decisions as consumers, citizens, and workers.
2. Students have a philosophy based on a good self-image which will enable them to meet challenges in a constructive way while maintaining personal integrity and accepting and appreciating individual differences.
3. Students have an understanding of the concept that life styles in a changing technological society are directly affected by those technological changes, and that education is an on-going process which will enable them to acquire or expand life skills needed to successfully participate in that society.
4. Students possess an understanding of and respect for themselves--their abilities, interests, values, aspirations and limitations--and use this understanding to set personal goals.

Improvement Practice to be Implemented:

The participant will develop a repertoire of attitudes, techniques and skills to be utilized in conducting activities from the Life Skills for Mental Health leaders' guides. Each participant will develop a plan for implementation within his/her classroom.

Objectives and Competencies for Implementing the Improvement Practice:

Objective I: The participant will understand the rationale for promoting positive affective and cognitive growth as a prevention strategy in mental health.

Activity: The participant will participate in a half-hour lecture/discussion session which outlines the objectives of the Life Skills for Mental Health activities and which identifies the rationale behind social and emotional skill development in three areas: 1) self acceptance, 2) feelings and 3) interpersonal relationships.

Alternate or Supporting Activity: The participant will view a fifteen minute slide/sound presentation, "Introducing Life Skills for Mental Health," which presents the above content. This activity would include discussion with trainer following the slide program.

Associated Performance Indicators:

1. Participant will identify the three areas of social and emotional skill development.

2. Participant will identify and list a minimum of three objectives of the Life Skills for Mental Health activities.

3. Participant will explain the health promotion/prevention function of Life Skills for Mental Health activities.

Preparation Phase:

Who: Local Training Teams

When: Session I (2 hours) of SDU Workshop

How: Lecture and/or slide presentation followed by discussion

Objective II: The participant will understand the organization and use of the Life Skills for Mental Health Activity Guides.

Activity: The participant will take part in a lecture/discussion session which outlines the organization of the guide and describes three ways the Life Skills activities can be used in the classroom.

Alternate or Supporting Activity: The participant will view a fifteen minute slide/sound presentation, Introducing Life Skills for Mental Health," followed by discussion with the workshop trainer.

Associated Performance Indicators:

1. Participant can identify and list the three activity sections of the Life Skills Guide and their relationship to the three areas of skill development.

2. Participant can identify and list 2 of the 3 ways to use Life Skills activities in the classroom.

Preparation Phase:

Who: Local Training Teams

When: Session I (2 hours) of SDU Workshop

How: Lecture and or slide presentation followed by discussion

Objective III: The participant will demonstrate skill in "Listening for Feeling" strategy.

Activity: Participant will take part in a three-hour session in which he/she is exposed to the "Listening for Feeling" strategy and in which he/she practices responding with "Listening for Feeling" statements made to the trainer or other participants. Participants will take part in demonstration of Life Skills activities in which "Listening for Feeling" is used.

Associated Performance Indicators:

1. Participant will complete a minimum of one "Listening for Feeling" statement which accurately identifies the feeling communicated in the speaker's statement.

2. Participant will be able to identify a minimum of two clarifying responses in addition to "Listening for Feeling."

3. Participant will complete the "Listening for Feeling" Worksheet and will accurately identify a minimum of 70% of the feelings communicated in the statements on the Worksheet.

Preparation Phase: Who: Local Training Teams

When: Session II (3 hours) of SDU Workshop

How: Short lecture followed by practice of "Listening for Feeling" strategy and completion of worksheet

Objective IV: The participant will demonstrate skill in "Giving Behavior Feedback" strategy.

Activity: The participant will take part in a 1 and 1/2 hour session in which the purposes, use and components of Behavior Feedback statements will be demonstrated. Participant will practice giving Behavior Feedback statements.

Associated Performance Indicators:

1. Participant will explain the purposes of Behavior Feedback statements as outlined on the "Behavior Feedback Worksheet."

2. Participant will identify and list the three essential components of a Behavior Feedback statement

3. Participant will be able to complete two or more accurate Behavior Feedback statements on worksheet

4. During workshop session, participant will make appropriate Behavior Feedback statements to instructors or to other participants in response to a minimum of two naturally occuring situations.

Preparation Phase: Who: Local Training Teams

When: Session III ($1\frac{1}{2}$ hours) of SDU Workshop

How: Short lecture followed by participant practice and completion of "Behavior Feedback Worksheet"

Objective V: Participant will demonstrate basic understanding of values clarification as a strategy for use in conducting Life Skills activities.

Activity: Participant will take part in a series of values clarification exercises which demonstrate Life Skills activities, followed by a lecture which outlines the use of values clarification and processes the steps involved in values clarification exercises.

Associated Performance Indicators:

1. Participant will complete a minimum of three values clarification exercises lead by the trainer
2. Participant can identify and list a minimum of three different types of values clarification exercises
3. Participant will identify and list the three major processes (steps) involved in values clarification

Preparation Phase: Who: Local Training Teams

When: Session IV (3 hours) of SDU Workshop

How: Participation in exercises and lecture

Objective VI: Participant will demonstrate an understanding of different types of creative drama and an awareness of the potential for using role play in Life Skills activities, in subject matter, and in dealing with classroom situations.

Activity: Participant will take part in a brief lecture which outlines different types of creative drama and simple building blocks for conducting role play in the classroom. Participant will take part in different types of creative drama techniques which demonstrate the building blocks to role playing. Participant will take part in Life Skills activities which use role playing.

Associated Performance Indicators:

1. Participant can identify and list a minimum of four building blocks to successful role play
2. Participant can identify and list a minimum of three helpful guidelines in setting up role play situations

3. Participant can identify and list a minimum of three ways to use role playing in the classroom

Preparation Phase: Who: Local Training Teams

When: Session V (3 hours) of SDU Workshop

How: Lecture and participation in role play activities followed by discussion

Objective VII: Participant will develop an understanding of the relationship between cognitive and affective learning

Activity: Participant will take part in a presentation on integrating affective learning in the classroom, followed by activities in which participants develop lesson plan ideas which use the Life Skills strategies in presenting regular classroom subject content.

Assoicated Performance Indicator:

1. Participant will develop a minimum of two lesson plan ideas which use any of the Life Skills strategies in presentation of regular subject content.

Preparation Phase: Who: Local Training Teams

When: Session VI (1½ hours) of SDU Workshop

How: Lecture and Lesson Plan Activity

Objective VIII: Participant will develop a brief, written plan for initial practice of the Life Skills for Mental Health activities in his/her classroom. This plan will be a basis for follow-up with the training team. Although each plan will be highly individualized, it must include the following:

1. a description of the students with whom the participant will work, by grade level
2. a description of three separate occassions on which the participant plans to utilize Life Skills activities in the school setting
3. identification (age range of guide and activity title) of a minimum of three activities that will be tried. The three activities should tap at least three of the Life Skills strategies
4. A process for conducting and reporting a self assessment of his/her successful completion of the identified activities

Associated Performance Indicator:

1. The participant will receive a rating of 4 or 5 on the scale below.

1	2	3	4	5
Plan does not clearly specify the 4 necessary components and is unacceptable		Plan is somewhat incomplete and needs revision	Plan is very complete and acceptable	

Preparation Phase: Who: Local Training Teams

When: one hour

How: Plans can be completed individually and approved by trainer, or can be completed in an additional hour of workshop time

(plan must be completed and approved within one week of final workshop session)

Objective IX: Participant will successfully demonstrate skill in conducting Life Skills activities.

Activity: In actual or simulated classroom situations, the participant will conduct a minimum of two Life Skills activities while being observed by the trainer.

Performance Indicators:

1. Participant will be able to identify specific problems he/she has in conducting Life Skills activities
2. Participant will achieve a score of 3 or better in using "Listening for Feeling" and other clarifying responses in conducting Life Skills activities

1	2	3	4
Uses clarifying responses in less than 40% of situations in which such responses would be appropriate	Uses clarifying responses in 40% - 70% of situations in which such responses would be appropriate	Uses clarifying responses in 70% - 90% of situations in which such responses would be appropriate	Uses clarifying responses in more than 90% of situations in which such responses would be appropriate

3. Participant will achieve a score of 3 or better in using "Behavior Feedback in conducting Life Skills activities.

1	2	3	4
Uses behavior feedback in less than 40% of situations in which it would be appropriate	Uses behavior feedback in 40% - 70% of situations in which it would appropriate	Uses behavior feedback in 70% - 90% of situations in which it would be appropriate	Uses behavior feedback in more than 90% of situations in which it would be appropriate

4. Participant will demonstrate ability to conduct role play exercises and will achieve a rating of 3 or better on the scale below.

1	2	3	4
Uses building blocks	1 plus	2 plus	3 plus
	assigns roles	follows guidelines in structuring role play	demonstrates ability to facilitate problem resolution or to terminate role play successfully

5. Partipcant will demonstrate ability to conduct values clarification exercises and will achieve a rating of 3 or better on the scale below.

1	2	3	4
follows step by step instructions	1 plus	2 plus	3 plus
	indicates purpose of exercise	uses clarifying responses or verbal door openers in response to students' comments	has students identify personal learning that occurred in exercise

Preparation Phase:	Who:	Local Training Teams
	When:	Training Follow-up
	How:	A minimum of 4 hours with Training Instructor on-site in participants's classroom or in follow up workshop or in a combination of workshop and classroom.

Objective X: Participant will develop a plan for implementing the Life Skills for Mental Health Program in his/her classroom for the assessment team. This plan will be used by the assessment team during their visit to the participant's classroom. Each plan will be individual, but must include the following:

1. a description of the students with whom the participant is working
2. a description of a minimum of two activities that will be conducted during the assessment visit. (Participant can note age range of guide, activity title and purpose of activity.) The activities conducted should tap at least three of the Life Skills strategies.
3. a brief description of the participant's plan for
   a) introducing each activity
   b) facilitating each activity
   c) concluding each activity (i.e., processing the activities to help students recognize the learning that occurred and its applicability to real life.)

Associated Performance Indicator:

1. The participant will receive a rating of 4 or 5 on the scale below.

1	2	3	4	5
Plan does not clearly specify the 3 necessary components and is unacceptable		Plan is somewhat incomplete and needs revision	Plan is very complete and acceptable	

Preparation Phase: Who: Local Training Teams

When: one hour

How: Plans can be completed individually and approved by trainer, or can be completed in an additional hour of workshop time

(plan must be completed before assessment can take place.)

On-The-Job Assessment

The on-the-job assessment will be based on the participant's individual plan for implementation. The procedures for the assessment, any instruments to be used, and the expectations of the team will be based on the approved implementation plan and will be discussed with the participant prior to the visit by the assessment team to the participant's classroom.

The evaluation team will include a member of the CMHC training team, a local school system professional who is familiar with the activity, or other trained professional staff from the LEA or DHR Division of Mental Health and Mental Retardation. Additional evaluators could include a staff development coordinator, curriculum director, principal, content specialist, or a professional peer.

The on-the-job assessment will be conducted during the time specified in the approved implementation plan and defined in the assessment plan. The evaluation team will furnish a written report of the on-the-job assessment to the training coordinator and a copy will be sent to the participant.

APPENDIX H

SOLICITATION MEMORANDUM FOR STATE-WIDE IMPLEMENTATION

SOLICITATION MEMORANDUM FOR STATE-WIDE IMPLEMENTATION

GEORGIA DEPARTMENT OF HUMAN RESOURCES

las Skelton, M.D./Commissioner

Division of Mental Health/Mental Retardation

47 TRINITY AVENUE, S.W., ATLANTA, GEORGIA 30334

March 14, 1978

MEMORANDUM

TO: Area Program Directors
Prevention Coordinators
Area Mental Health Programs

FROM: William S. Allerton, M.D.
Director
Division of Mental Health
and Mental Retardation

RE: Life Skills for Mental Health Program

The Life Skills for Mental Health Program is nearing the end of its first year of implementation on a pilot basis. Community response has been very favorable, and the Division is going ahead with plans to offer the program State wide, beginning with the new school year in Fall of '78. Now is the time for you to confer with your staff, and perhaps with appropriate people in your community, to decide whether or not you want to offer the Life Skills for Mental Health Program in your service area.

As you are aware, the Life Skills Program includes a series of teachers guides and a training workshop to prepare teachers (or other youth group leaders, such as scout leaders, church group leaders, etc.) to use the guides. The teachers' guides are developed and are in use now in the pilot areas. They would be supplied to you by the Division's Prevention Unit. Your responsibility would be to coordinate implementation of the program in your service area, primarily by providing the training workshop and follow up. Specifically, your responsibilities would include the following:

1. Generating community awareness of the Program.
   We are taking a "soft sell" approach to the Life Skills Program. It is a resource available to schools upon request. The Center's role is to insure that schools and other potential users are aware of the Program and can decide to participate or not based on good information. You would have access to an excellent sound/slide presentation which describes the Program. Also, you would have a good supply of the enclosed brochure.

2. Participating in a "Training of Trainers" Session.
Each Center that participates in the Life Skills Program will be asked to select a four-member team who will provide the training workshop as it is requested in the Center's service area. All four members of the team should plan to attend the Training of Trainers Session which will begin the evening of July 10, 1978 and run for two full days. (July 10-12) Travel and perdiem expenses will be covered.

   The training team coordinator should be a CMHC staff person, but need not necessarily be the Prevention Coordinator. Other team members may also be CMHC staff or they may be other community resources who have training experience in affective education skills (communication skills, values clarification, Parent Effectiveness Training or Teacher Effectiveness Training, or similar programs). We encourage Centers to draw on community resources, particularly resources that are familiar with school system needs and have had experience in teacher training. The pilot teams have drawn on a variety of resources from their communities, including school system people, family mediation center staff, substance abuse program people.

   There is a good reason for asking each Center to have a training team of four members. Each teacher training workshop can be led effectively by two trainers. By having four members on the training team, each Center will have two teams capable of conducting the training workshops. The responsibility of providing the training workshop can be spread across more shoulders, and there will be less stress on the already demanding schedules of CMHC staff.

3. Providing the training workshop and follow up to teachers and other adult leaders.
It is hard to suggest the amount of time this will involve, since that will depend on the number of interested schools in your area. Training sessions should be scheduled to fit the convenience of the participants and the training team. Each training session covers twelve hours of time and can be formated in different time blocks. This does not include preparation time or follow up to teachers once they have had some time after the training to try the Life Skills activities in their classrooms. Centers who choose to do so can offer the Life Skills training to teachers for certificate renewal credit, through an agency staff development plan that has been approved by the State Department of Education. Training for CR credit involves twenty hours of time; this includes four hours of follow up.

If your Area Program wants to participate in the Life Skills program, send a letter to Xenia Wiggins at the following address:

Prevention Unit
Division of Mental Health and
Mental Retardation
618 Ponce De Leon Ave.
Atlanta, Georgia 30308

We need to hear from you no later than May 1, 1978, in order to complete plans for the July Training of Trainers. In your letter, please indicate the CMHC staff person who will serve as training team coordinator and identify the remaining team members. Ask all training team members to mark their calendars for July 10-12, 1978, for the Training of Trainers session.

Under separate cover, we are sending you one complete set of the Life Skills guides. This will provide more detailed information on the Program. Also, feel free to call Xenia at (404) 894-5030 or GIST 222-5030.

cc: Consortium Chairpersons
District Health Directors